PA PROMISe™
User Manual

PA PROMISe™ Provider Electronic Solutions Software User Manual

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HP Enterprise Services
Attention: Documentation Unit
PA MMIS
225 Grandview Ave
MS A20
Camp Hill, PA 17011

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1 Introduction to Provider Electronic Solutions

The Provider Electronic Solutions software supports the processing of Health Insurance Portability and Accountability Act (HIPAA) ready transactions. The HIPAA-ready form types available for the Pennsylvania Office of Medical Assistance Programs (OMAP) include the following:

- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient
- 837 Professional
- NCPDP Pharmacy
- Pharmacy Eligibility
- NCPDP Pharmacy Reversal
- 276 Claim Status Request
- 277 Claim Status Response
- 270 Eligibility Request
- 271 Eligibility Request Response

This version of the Provider Electronic Solutions software was released for PA PROMISe™ August 2015.

Please take a few moments and read the portions of this user manual that pertain to your type of billing. A number of changes have been made to the billing procedures, forms, and fields. These changes are explained in the form completion sections.

Also, please note that the completion information given in this manual does not guarantee a claim's payment during adjudication. Please obtain completion instructions from the Pennsylvania Medical Assistance Provider Inquiry units. Contact information can be found in Section 14.

2 System Requirements

The Provider Electronic Solutions software requires the following system requirements before it can be installed on a PC:

System Requirements for PES (Provider Electronic Solutions)	
Minimum	**Recommended**
Pentium II	Intel Core i3 2100 or AMD Phenom II X4 980 BE
Microsoft ® Windows 2000 or Windows XP	Microsoft Windows 2008 R2 or Windows 7
Microsoft Internet Explorer 8.0 or higher	Microsoft Internet Explorer 8.0 or higher
256 Megabytes RAM	256 Megabytes RAM
100 Megabytes Free Hard Drive Space	100 Megabytes Free Hard Drive Space
800 X 600 Resolution	1024 X 768 Resolution
Using the WEB Option – LAN- Office Network, Broadband, DSL, cable modem or T1 must be used.	Using the WEB Option – LAN- Office Network, Broadband, DSL, cable modem or T1 must be used.
	CD-ROM Drive
Printer with MS Sans Serif font installed	Printer with MS San Serif font installed

Notice: The information contained in this software should be guarded in accordance with the Health Insurance Portability and Accountability Act of 1996 - Privacy Rule 45 CFR Part 164. It is the responsibility of the Covered Entity as well as its Business Associates to comply with HIPAA Privacy and Security standards in order to safeguard individually identifiable information and protected health information.

3 Installation Overview

The Provider Electronic Solutions software can be installed on either your local hard disk drive (Typical Installation) or a network (Workstation Installation). This software can be installed on as many PCs as needed. Upon completion, store the original Provider Electronic Solutions software CD-ROM and/or download files in a safe place. In the event the program and files are damaged or deleted, the original files are needed to re-install the Provider Electronic Solutions *software*.

> **Note:** Use of software for purposes other than intended or any altering of software, such as files being loaded into the software, are not supported by the EDI Department.
>
> **Note:** Please disable all Anti-Virus software before proceeding with the installation or upgrade of the PES software.

Important note for users applying the upgrade: Prior to running the upgrade complete the following:

- Make sure all claims have already been submitted and are in an "F" (Finalized) status. DO NOT have any claims that are in "Incomplete" or "Ready" status.
- Please Archive claims that are in a Final status.
- Create a copy of the Database (panewecs.mdb) and save it so that you have a backup of your database.

UPGRADES MUST BE INSTALLED IN SEQUENTAL ORDER (3.57, 3.58, 3.59, 3.60, 3.61, 4.00)

> **Note:** For the first submission after upgrading to the Provider Electronic Solutions (PES) Software Version 4.00 – Do not "**copy claims**" that were created using PES version 3.61 or earlier. Please key in all information for first submission after the upgrade to the PES version 4.00. For all submissions following, you can "copy claims" and submit using this information.

3.1 Installation from a Downloaded File

You can download the Provider Electronic Solutions software from the DHS Web site at http://promise.dpw.state.pa.us/ePROM/_ProviderSoftware/softwareDownloadMain.asp_Please open the Instructions to download from the web * and follow the instructions to download the Provider Electronic Solutions software.

Using the links on the Website, Please install the Upgrade using the following steps:

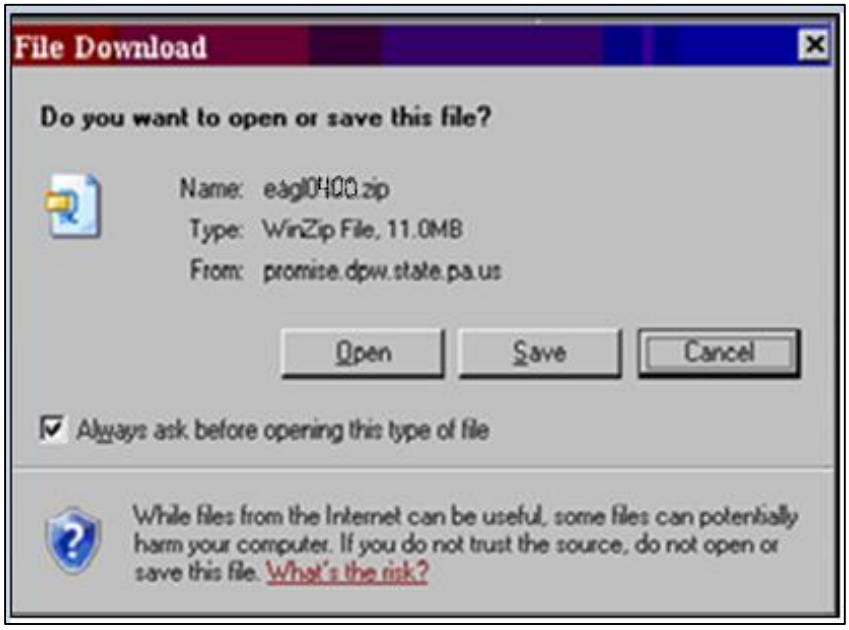
1. On the Website, (Do not use the links below) Click on one of the following:

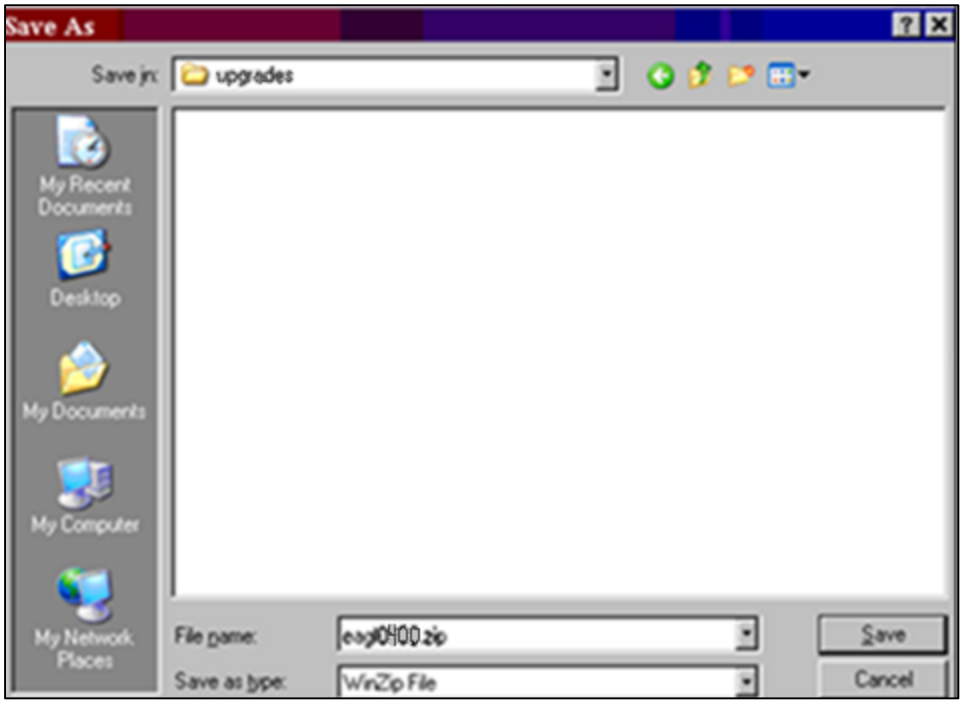
   Download the software upgrade 4.00

   Download the software upgrade 3.61

   Download the software upgrade 3.60

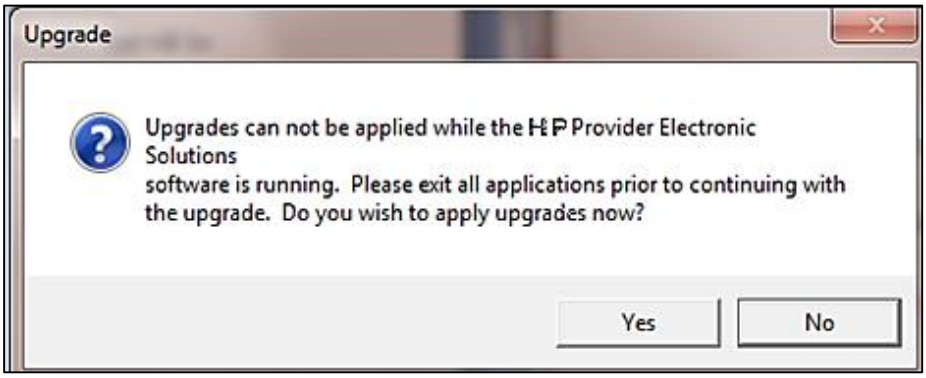
2. You will be prompted to save the file to a location on your computer similarly to the picture below. Click on the Save button.

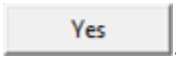

File Download
Do you want to open or save this file?
Name: eagl0400.zip
Type: WinZip File, 11.0MB
From: promise.dpw.state.pa.us
Open
Save
Cancel
Always ask before opening this type of file
While files from the Internet can be useful, some files can potentially harm your computer. If you do not trust the source, do not open or save this file. What's the risk?



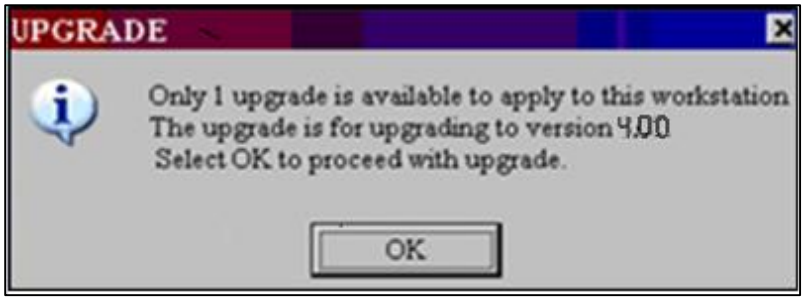
3. Browse to the location you wish to save the file. You need to save the file to the upgrades folder where you installed your database file similar to the picture below. (ex: C:\papromise/upgrades) Click

to download the file and save it to the location you indicated.
4. Once the file successfully downloads you will need to apply the upgrade. To do this, go to the Start Menu, Programs, PA PROMISe Provider Electronic Solutions Software, and click on the Upgrades folder. This will launch the upgrade program similar to the picture below.
5. The following message will display. (If you do not see this message, the Upgrade file was not saved to the correct location.)

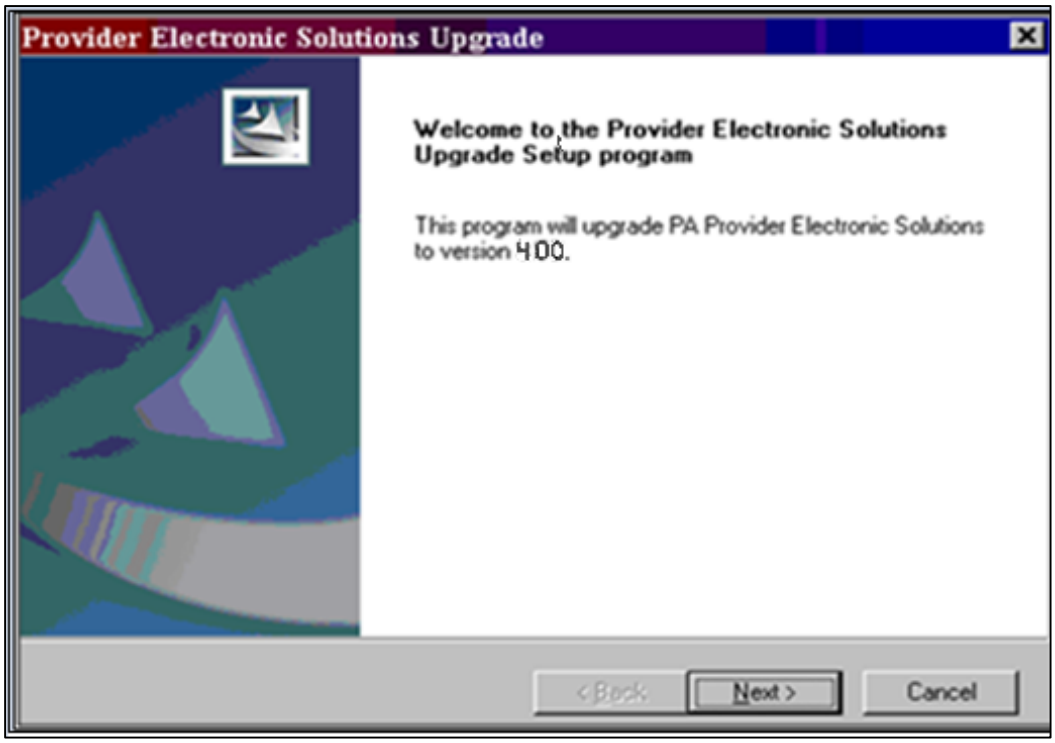

Upgrade
Upgrades can not be applied while the HP Provider Electronic Solutions
software is running. Please exit all applications prior to continuing with the upgrade. Do you wish to apply upgrades now?
Yes
No

6. Click on 

. The upgrade process will launch, and indicate the upgrade version that will be applied. Click Yes. The following screens will display.

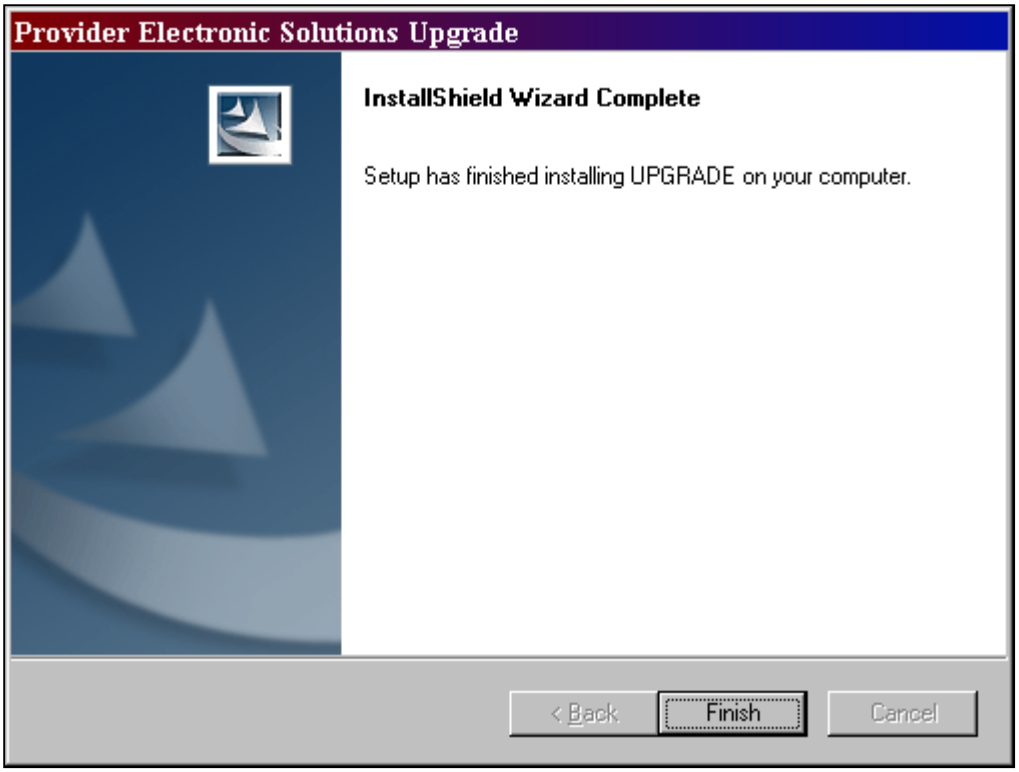

UPGRADE
Only 1 upgrade is available to apply to this workstation.
The upgrade is for upgrading to version 4.00
Select OK to proceed with upgrade.
OK

7. Click OK and the following screens will display.


Provider Electronic Solutions Upgrade
Welcome to the Provider Electronic Solutions Upgrade Setup program
This program will upgrade PA Provider Electronic Solutions to version 4.00.
< Back
Next >
Cancel

8. Click

. The upgrade process will complete. Once the process is finished the following screen will display.



9. Click Finish. The upgrade has been successfully added to your installation of the Provider Electronic Solutions software. You can now log in, using your current User ID and Password and begin using the software.

> **Note:** Use of software for purposes other than intended or any altering of software, such as files being loaded into the software, are not supported by the EDI Department.

3.2 Installation from A CD-ROM

The Provider Electronic Solutions software was designed for installation on the hard drive of a personal computer (PC) or to a network. To simplify installation, an automatic installation program is already on the CD-ROM. Follow the installation instructions listed below:

Step 1. Place the CD-ROM in the computer drive. The system reads the CD-ROM and automatically proceeds through the installation process.

If the Windows AutoPlay feature is turned **off,** the software will **not** automatically proceed through the installation process. Perform the following steps to begin the installation process:

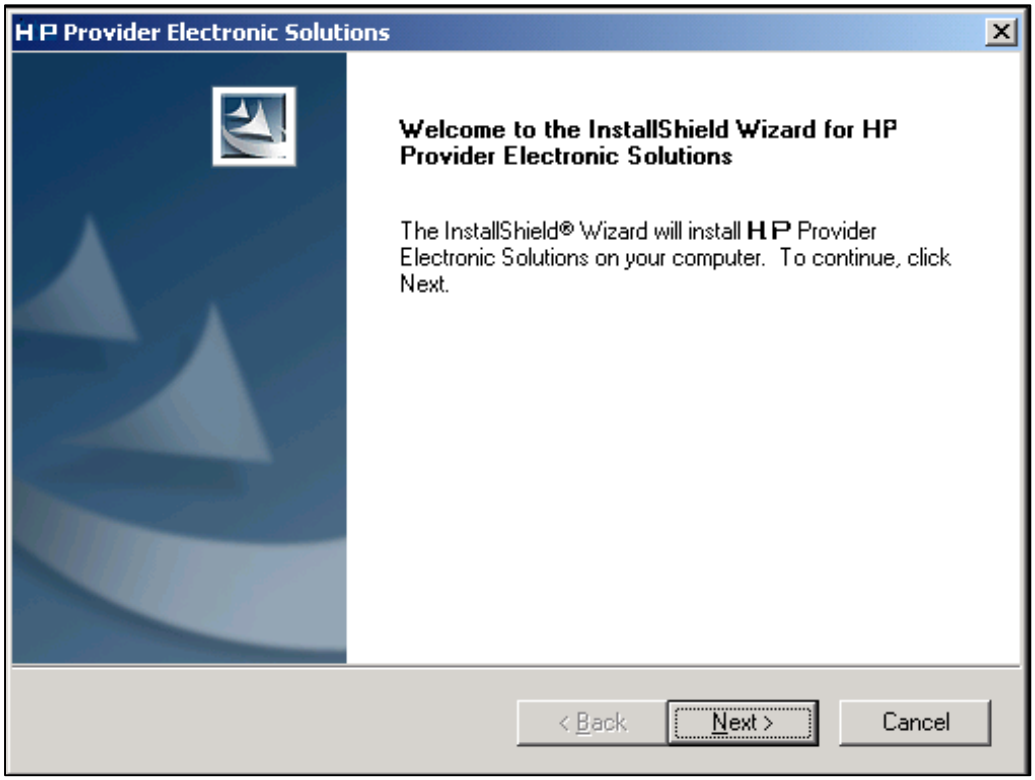
Step 2. Select the **Start/Run** option.

Step 3. Click Browse... and select the appropriate CD-ROM drive and highlight **setup.exe**.

Step 4. Click Open.

Step 5. Click OK and proceed to **Step 2**.

Step 6. When the Welcome screen is displayed, click Next >.


H P Provider Electronic Solutions
Welcome to the InstallShield Wizard for HP Provider Electronic Solutions
The InstallShield® Wizard will install H P Provider Electronic Solutions on your computer. To continue, click Next.
< Back
Next >
Cancel

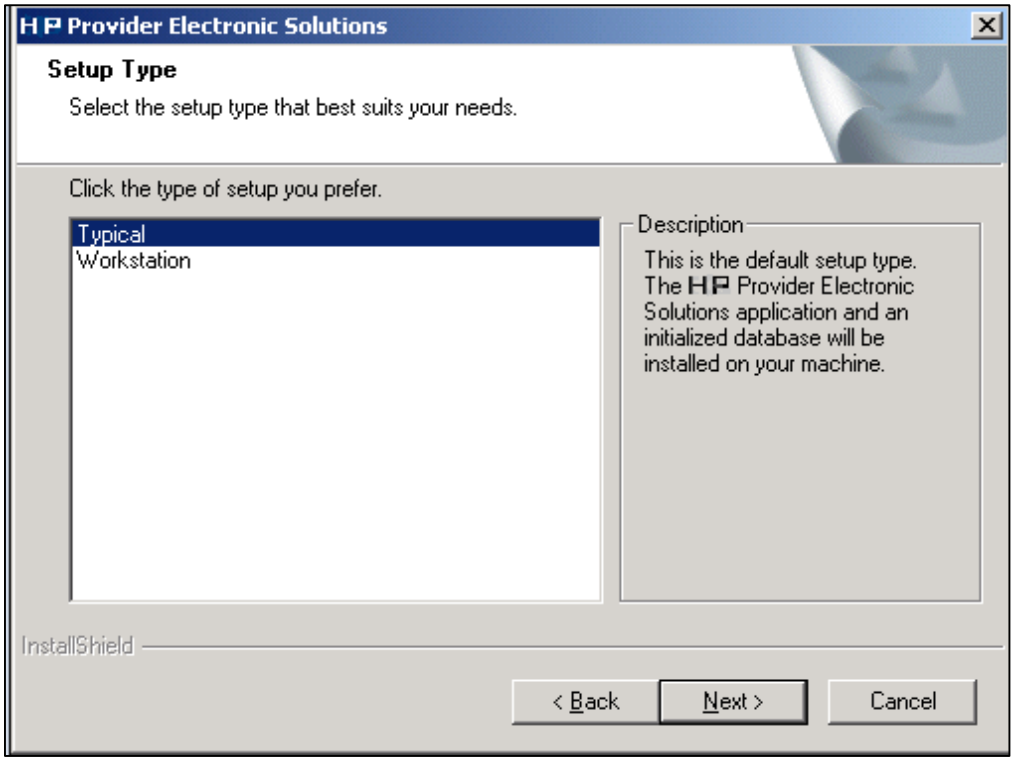
Step 7. When the Setup Type screen is displayed, click either **Typical** or **Workstation,** and then click Next >.

Note: This section applies to full install for the DHS WEB site download or the CD ROM Installs

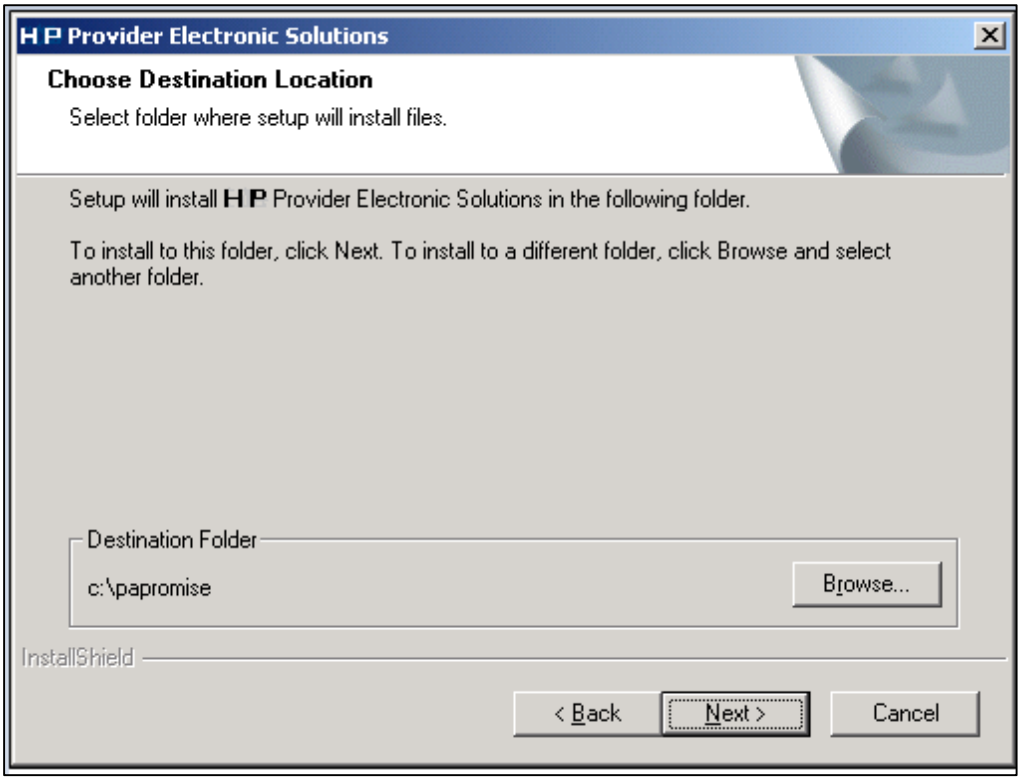
A **Typical installation** installs all files, including the database. Use this installation to install the software to a stand-alone PC, or to initially install the software to a network server. Most installations are typical installations.

A **Workstation installation** is used to add the software to additional PCs that are connected to a network server, where all users share a database. This installation type does not load the database files to the PC; however, it does allow for sharing the database files that were installed to the network.

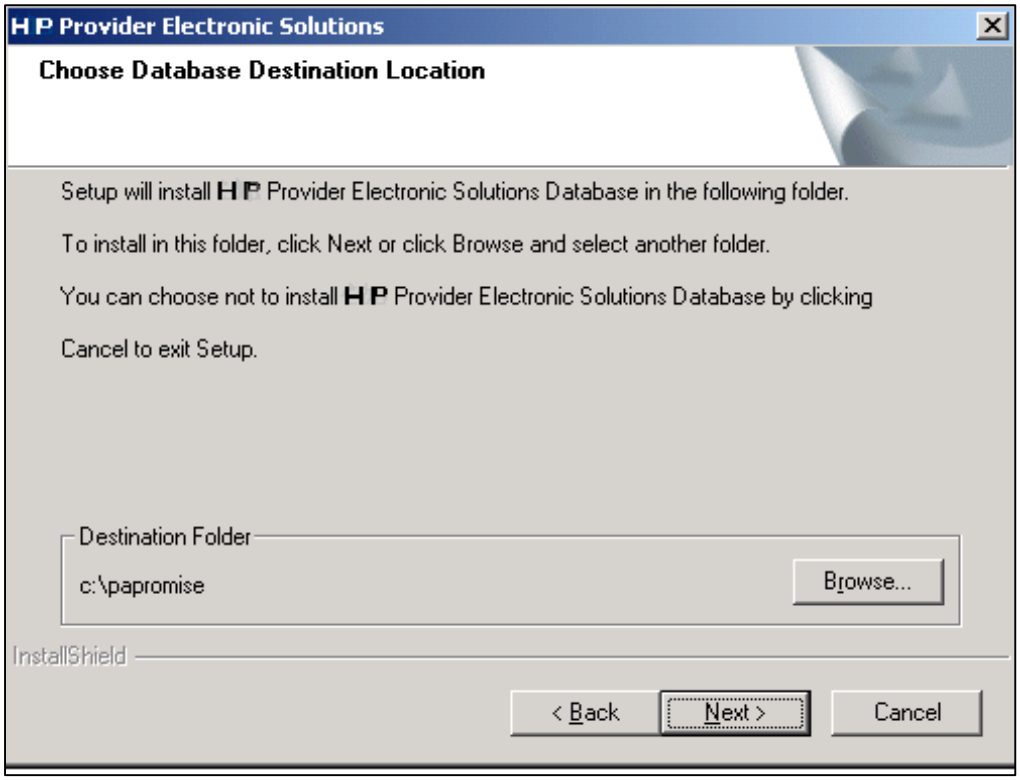
Note: Use of software for purposes other than intended or any altering of software, such as files being loaded into the software, are not supported by the EDI Department.


HP Provider Electronic Solutions
Setup Type
Select the setup type that best suits your needs.
Click the type of setup you prefer.
Typical
Workstation
Description
This is the default setup type. The HP Provider Electronic Solutions application and an initialized database will be installed on your machine.
InstallShield
< Back
Next >
Cancel

Step 8. When the Choose Destination Location screen is displayed, click **Next >** to install at C:\papromise, which becomes the default directory. If the software is to run from a network rather than the PC hard drive, select the appropriate destination drive and click **Next >**.

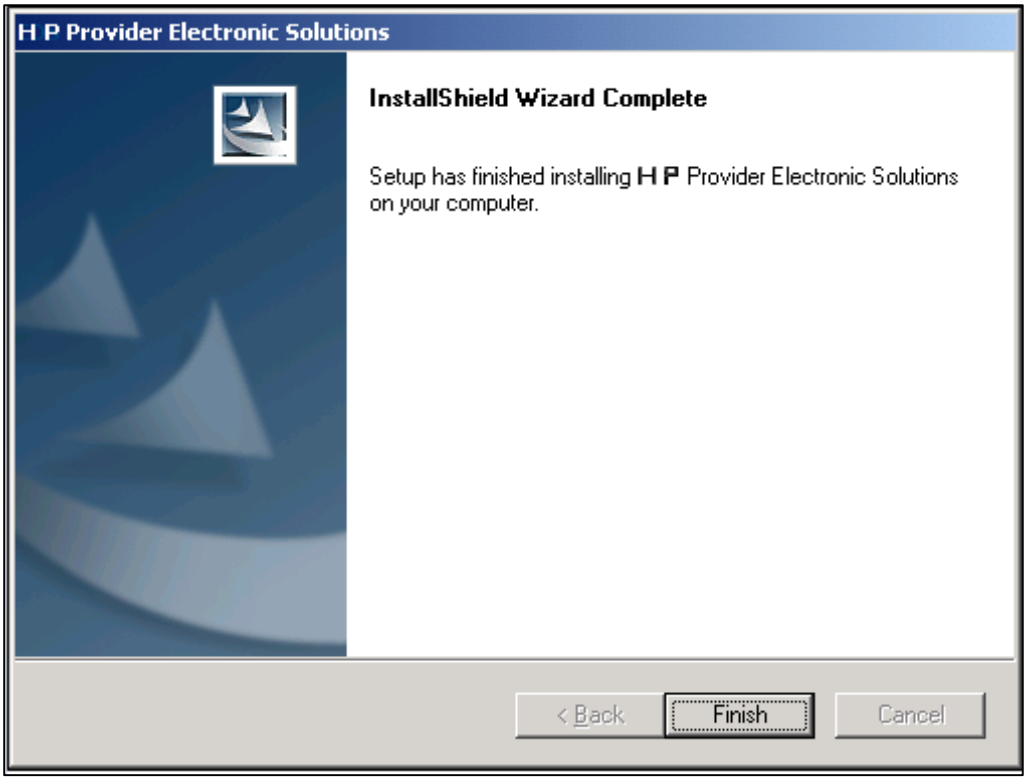

H P Provider Electronic Solutions
Choose Destination Location
Select folder where setup will install files.
Setup will install H P Provider Electronic Solutions in the following folder.
To install to this folder, click Next. To install to a different folder, click Browse and select another folder.
Destination Folder
c:\papromise
Browse...
InstallShield
< Back
Next >
Cancel

Step 9. When the Choose Database Destination Location screen is displayed a second time, click Next > to install at C:\papromise, where the database files are loaded and become a default directory. If installing the software to a network, select the appropriate destination drive and click Next >.


H P Provider Electronic Solutions
Choose Database Destination Location
Setup will install H P Provider Electronic Solutions Database in the following folder.
To install in this folder, click Next or click Browse and select another folder.
You can choose not to install H P Provider Electronic Solutions Database by clicking
Cancel to exit Setup.
Destination Folder
c:\papromise
Browse...
InstallShield
< Back
Next >
Cancel

Step 10. When the Information screen is displayed, click **OK**. This screen shows the drive and directory where the files were installed.

Step 11. When the Setup Completed screen is displayed, click **Finish** to complete the setup.


H P Provider Electronic Solutions
InstallShield Wizard Complete
Setup has finished installing H P Provider Electronic Solutions on your computer.
< Back
Finish
Cancel

3.3 Install the Software to a Network

Step 1. Install the Provider Electronic Solutions software as a:

Typical installation

Step 2. When asked where you would like to install the database:

Select the location on the network

Step 3. To install the software on the workstation**:**

Install the software as described above

Step 4. When asked to choose between typical and workstation installation:

Select workstation installation

Step 5. When asked where the database is located**:**

Indicate where it was installed in the above step

4 Access the Application

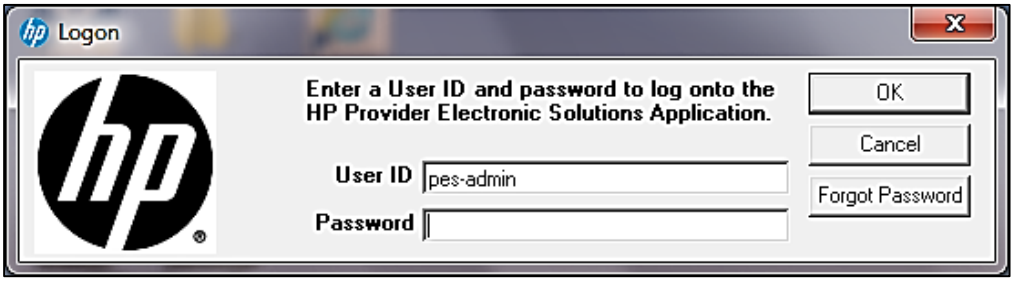
Step 1. To access the application, perform the following:

Double-click the PA HP Provider Electronic Solutions folder from the desktop, and then select HP Provider Electronic Solutions,

or

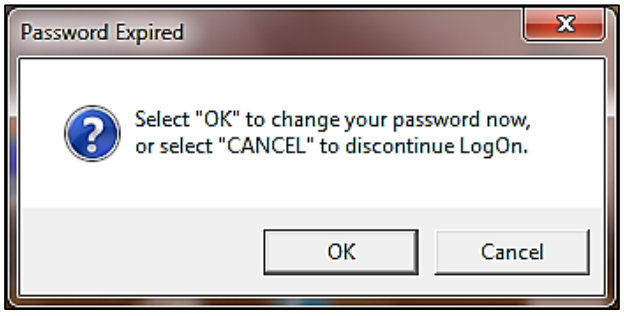
Select the **Start** button in the bottom left-hand corner of the screen, select the Program option, and then select **PA HP Provider Electronic Solutions**.

Step 2. When the Logon screen is displayed, use **pes-admin** as the default User ID **(DO NOT CHANGE)**. Type the default password, **hp-pes,** and click OK.



Note: The User ID is always **pes-admin** unless additional User IDs are set in the security menu.

Step 3. The first time you log on, a **Password Expired** box is displayed. Click OK.



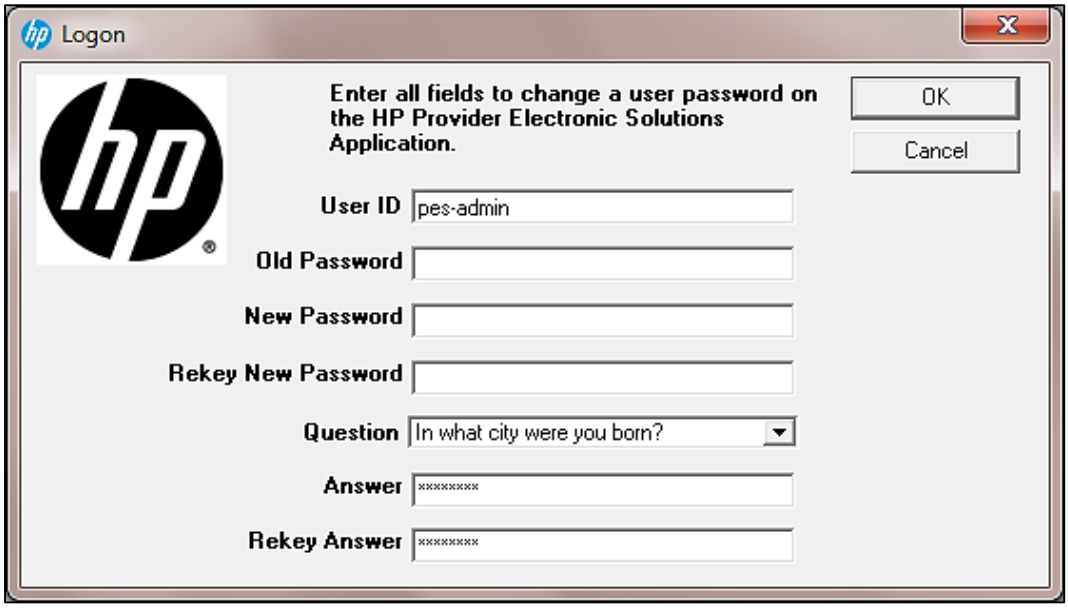
Step 4. The Logon screen prompts you to change your password.

Type the old password, **hp-pes**, in the Old Password field.

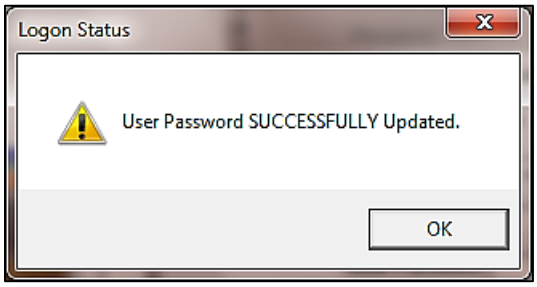
Type your new password in the New Password field. Your new password must be a minimum of five (5) and a maximum of ten (10) alphanumeric characters. **This password is case sensitive.**

Retype your new password in the Rekey New Password field.

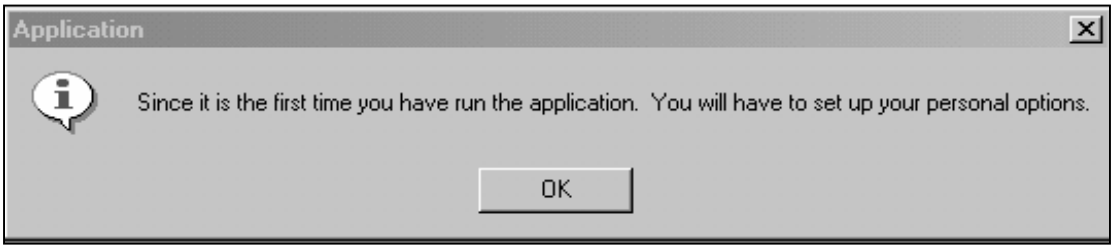
Click OK.



Step 5. When the Logon Status box is displayed and you see that your password was successfully updated, click OK.



Step 6. When the Application box is displayed and prompts you to establish your personal options, click OK.Need to add this



5 Complete Transmission Options

The first time you log on to the application and change your password, you are required to set up your Transmission Options, and the Options box is automatically displayed.

If you have logged on to the software previously and would like to update your Transmission Options, access the Tools menu from the main screen and click the Options selection.

The Options box records the information necessary to transmit forms and receive responses. It is important that each tab in the Options box be completed accurately.

5.1 Web – Internet (ONLY OPTION AVAILABLE)

The Web screen contains your system's Web information. Select the appropriate settings for connection to the Web.

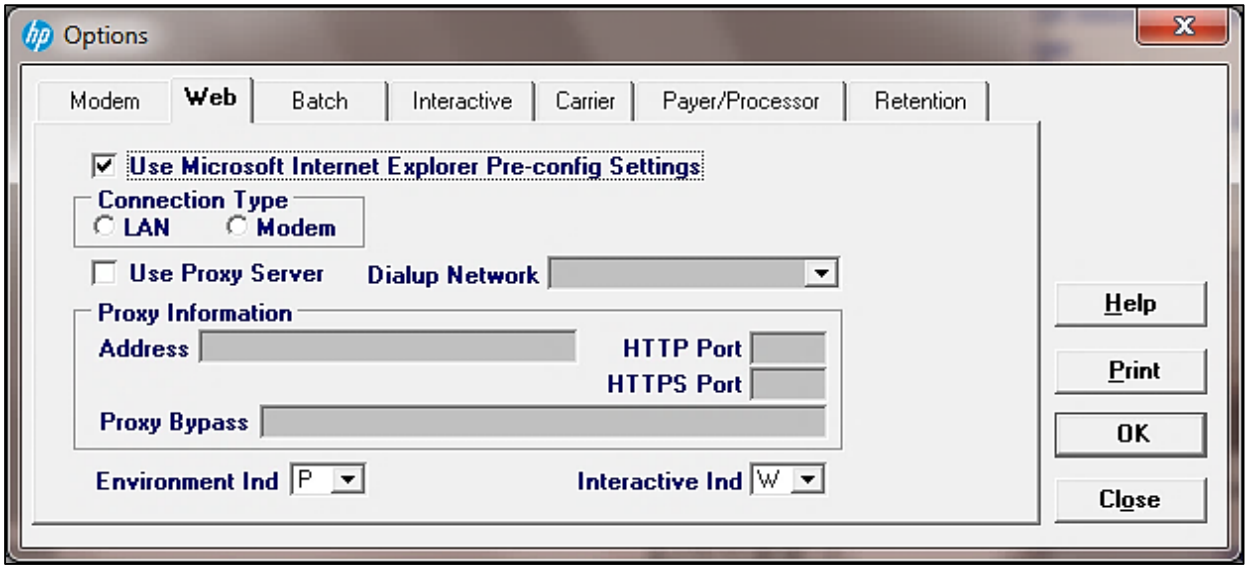
> **Note:** You can use regular internet connections installed on your computer to use the software to send files.

You need to manually complete the fields for this screen. You can use the following steps to set up the software in order to send and receive files using the PES software:

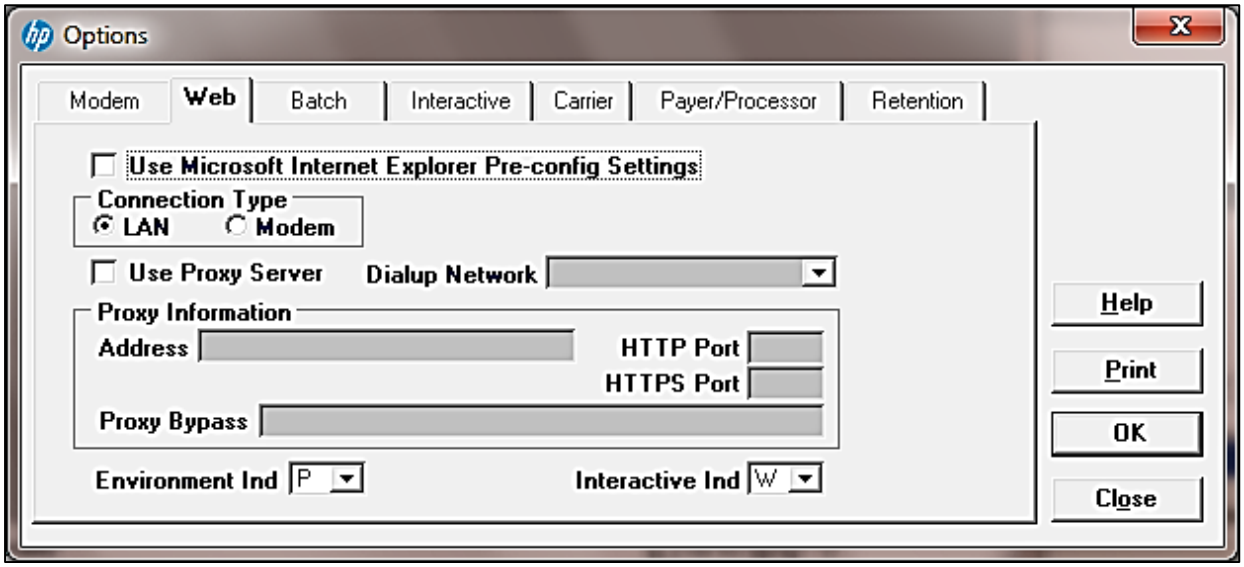
Step 1. Select **Tools,** then **Options**. On the **Web** tab you can choose the settings that apply to the type of internet connection that you have.

Step 2. The "**Use Microsoft Internet Explorer Pre-config Settings**" is a checkbox that allows you to elect to use the Microsoft Internet Explorer configuration settings. Checking this box indicates that the Provider Electronic Solutions application will use the same registry settings as the Microsoft browser to connect to the internet. It defaults to checked or the pre-config settings.

> **Note:** It is recommended to leave this box checked as the default setting.
>
> **Note:** PES provides a Web-based Interactive communication method. In order to use the Web/BBS for Interactive claims choose W for Web, (B for BBS is no longer applicable.)



- **Connection Type** is an indication of the Internet connection that is established through the LAN (Modem is no longer available). If "Use Microsoft Internet Explorer Pre-config Settings" is unchecked, "Connection Type" will default to LAN. This is selected when using a proxy setting for the PES application. The Connection Type indicates the Internet connection is established through a LAN.
    - LAN – office network, broad band, DSL, cable modem
    - Modem – analog is no longer available.
    - Dialup Network – is no longer available.



Step 3. **Use Proxy Server** should be checked when a proxy server is used to connect to the internet. It is most commonly used with a LAN connection. If checked, the Proxy Information fields, including Address, HTTP Port, HTTPS Port, and Proxy Bypass will be unprotected for entry. Address, HTTP Port and HTTPS Port will be required entry.

Step 4. **Dialup Network IS NO LONGER AVAILABLE.**

Step 5. **Proxy Information Address** is required entry when "Use Proxy Server" is selected. This is the address (Universal Resource Locator or URL) of the proxy server used to connect to the internet.

Step 6. **HTTP Port** is required entry when "Use Proxy Server" is selected. This is the port number that the proxy server uses for standard Hyper-text Transfer Protocol (HTTP) communication.

Step 7. **HTTPS Port** is required entry when "Use Proxy Server" is selected. . This is the port number that the proxy server uses for secure Hyper-text Transfer Protocol (HTTPS) communication.

Step 8. **Proxy Bypass** is optional entry when "Use Proxy Server" is selected. This is the address's (URL's) that do not use the proxy server to be rendered.

Step 9. Select the **Environment Indicator** that you will be using. If you are sending test files for Certification, you would set this to **T**. If you are sending production files for processing into the PROMISe™ system you will set this to **P**. Environment Ind defaults to P, Production environment. This field is used in formatting the X12 transactions.

Step 10. **Interactive Ind** – Choose W Web for the Web-based Interactive communication method ***(B BBS for BBS modem method IS NO LONGER AVAILABLE)***.

Note: After obtaining the Provider Electronic Solutions Software, you will need to register at the PROMISe™ Transaction Certification Registration Form link below. However, you will not need to submit testing for HIPAA/PROMISe™ certification

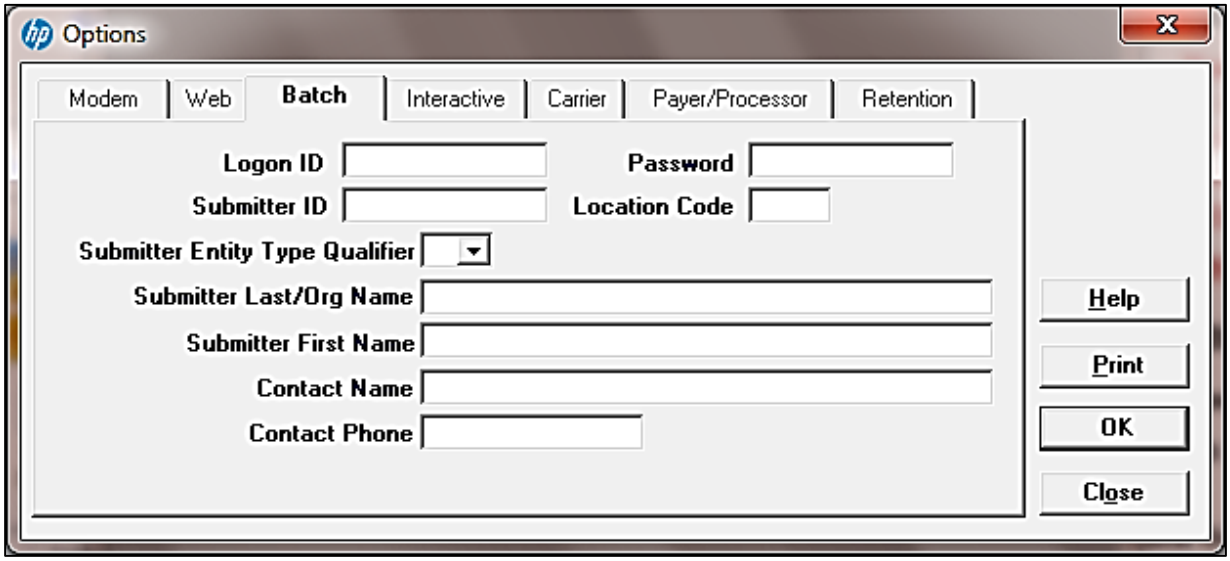
with HP Enterprise Services.
http://www.dhs.state.pa.us/provider/promise/certification/index.htm

5.2 ***Modem is no longer available.***

5.3 Batch Screen

The Batch screen contains information related to submitting batch files. To access the Batch screen:

Step 1. Click the **Batch** tab in the **Options** box.



Step 2. Enter the data requested for each field, as described here:

Web/BBS Logon ID	ID code assigned to you. This code is required for batch submission. HP Enterprise Services provides you with a Production Web/BBS Logon ID prior to submission of a file. After obtaining the Provider Electronic Solutions Software, you will need to register using the PROMISe™ Transaction Certification Registration Form. However, you will not need to submit testing for HIPAA/PROMISe™ certification with HP Enterprise Services.
Web/BBS Password	Identifies your logon password. Use this password to verify the Web/BBS Logon ID that you use to log on to submit claims. HP Enterprise Services provides you with a Web/BBS Password prior to submitting claims after you have registered using the PROMISe™ Transaction Certification Registration Form. **Note:** For security purposes, when you use the Web method option, your ***password expires every 30 days!*** PES will prompt you to update your Web login password when it expires. See Instructions for changing the Web Password below.

Submitter ID	If you have a Master Provider Index (MPI) number (PROMISe™ Legacy Numbers) assigned by DHS, enter that value in this field. If you are a billing service or other entity that does not have an MPI number, enter the same value that you entered in the BBS Logon ID field into this field.
Service Location	Enter the 4-digit Service Location number associated with the MPI number in this field. If you entered the BBS Logon ID value in the Submitter ID field, enter XXXX in the Service Location field.
Submitter Entity Type Qualifier	Identifies whether the user is a person or non-person. A person is defined as an individual, Pennsylvania Medical Assistance (MA) provider. A non-person is defined as a group, facility, or billing service.
Submitter Last/Org Name	Last name of an individual provider or the business name of a group, facility, or billing service.
Submitter First Name	First name of an individual provider. Complete this field only if the Entity Type Qualifier is "Person."
Contact Name	Enter the name of the contact person – This is a **required** field. Cannot be the same as the Submitter Last/Org Name.
Contact Phone	Contact Phone – Enter the phone number of the contact person. Contact Phone is always **required** and must be max length 11.

5.4 How do I reset my Web password?

For security purposes, your web password expires every 30 days. When you submit a batch when your password expires, the *Web Password Reset* screen will display prompting you to change your web password.

Step 1. In the **Old Password** field, enter your old password. If you can't remember your password, refer to the What if I can't remember my Web password? Section of this document.

Step 2. In the **New Password** field, enter a new password. To select a new password see the password rules table.

PASSWORD RULES
May not be the same as the Logon ID
May not be the same as the current password
Must contain only alphanumeric characters (A-Z, a-z, or 0-9)
Must contain at least one alphabetic character (A-Z or a-z)
Must contain at least one numeric character (0-9)
Must not have the same character appear more than twice
Must be 5 – 9 alphanumeric characters in length

Step 3. In the **ReKey New Password** field, re-enter your new password.

Step 4. Click the **OK** button.

Step 5. The Web Password Status screen displays **Web Password SUCCESSFULLY Updated.** To continue, click the **OK** button.

5.5 What if I can't remember my Web password?

Step 1. From the Main menu, select **Tools**.

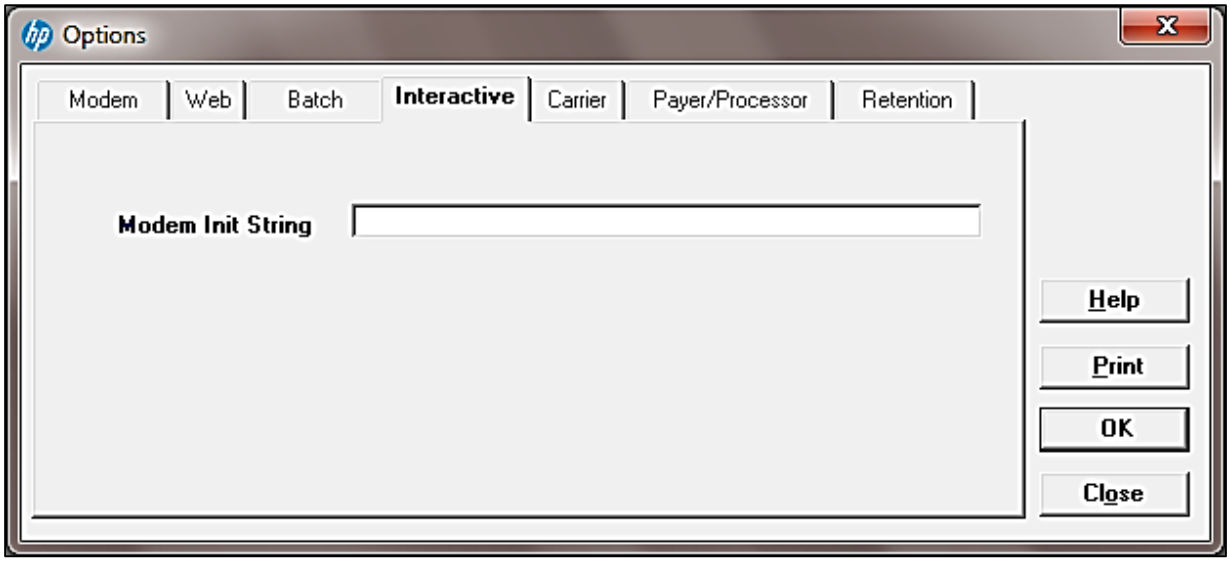
Step 2. From the Tools sub-menu, select **Options**.

Step 3. From the Options screen, select the **Batch Tab**. Your Old password will display in the password field.

Interactive

The Interactive screen contains information related to submitting interactive files.

Step 1. To access the Interactive screen, click the Interactive tab in the Tools/Options box



Note: Data for this screen populates automatically after the modem type is selected on the Modem screen. This also includes a Web/BBS submission method if you receive the message that a modem needs to be selected but will not be used.

Note: If using the Web/BBS this does not need to be completed.

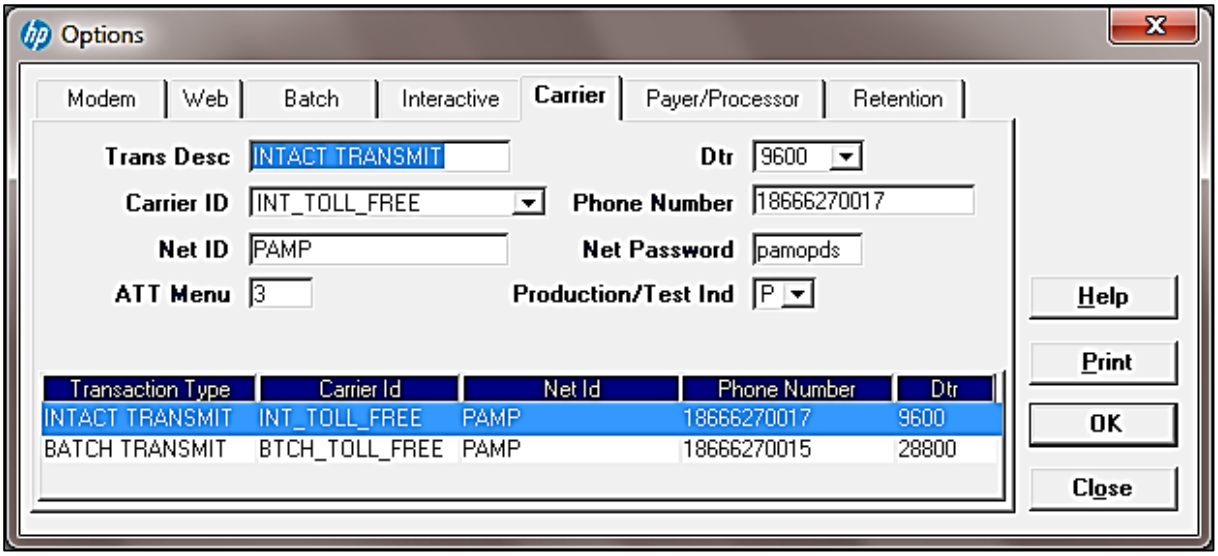
Modem Init String	This is no longer available. Initialization string of modem commands used to **select a modem type.** **Note:** Change the string in this field only under the direction of a representative from the HP Enterprise Services Provider Assistance Center (PAC 1-800-248-2152 or 717-975-4100).

5.6 Carrier

The Carrier screen contains information related to transmitting your files. To access the Carrier screen:

Step 1. Click the **Carrier** tab in the **Tools/Options** box.

The software comes preloaded with Interactive Transmit and Batch Transmit options at the bottom of the screen. Fields populate with the associated data. These two transaction types are submitted through the Provider Electronic Solutions software.



Step 2. Enter the data requested for each transaction type listed below.

Interactive Transaction	When a single form is submitted and a response is received back within a few minutes.
Batch Transaction	When several forms are submitted at the same time and processed through the system. This one batch transaction type is used to submit both 837 claim files and Batch 270 eligibility requests.

Step 3. Enter data for each transaction description, regardless of the transaction type.

Step 4. Click a transaction description listed at the bottom of the Carrier screen and complete all applicable fields.

Step 5. Click the other transaction description and complete all applicable fields.

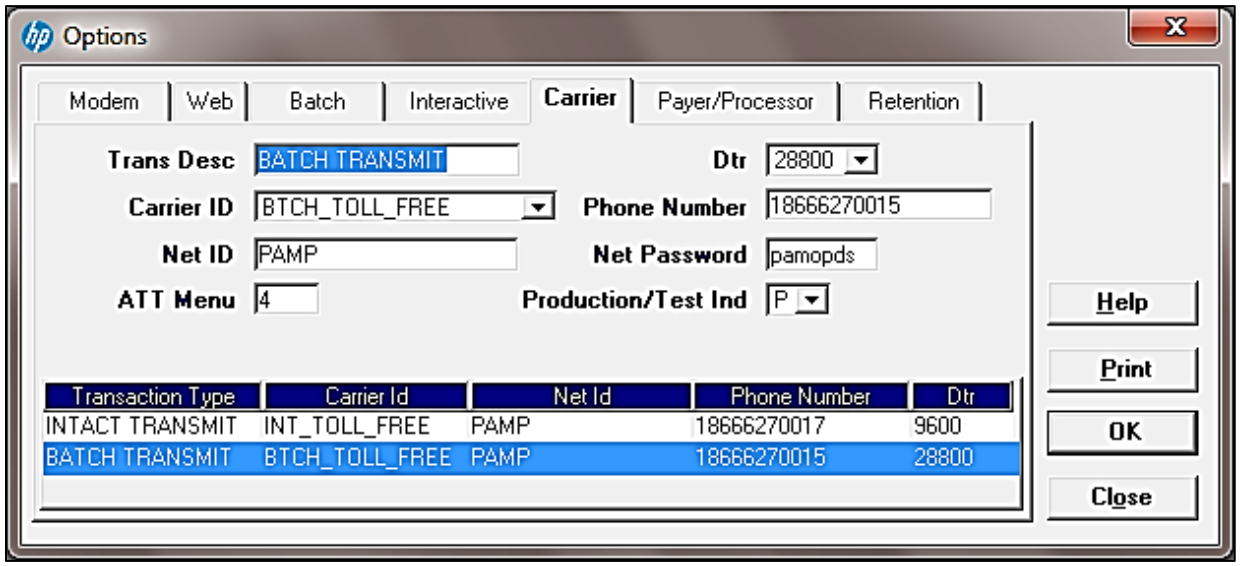
Step 5.1 Complete Carrier.

Step 6. Choose **Intact Transmit** from the bottom of the screen under Transaction Type to configure the Interactive Transaction Carrier.

DTR:	Leave this value at the automatically populated value (9600).
Carrier ID:	Select **INT_TOLL_FREE** from the drop down list.
Phone Number:	Automatically populates when the Carrier ID is selected. If you need to dial an access code prior to accessing an outside line, enter that number followed by a comma prior to the phone number. (ex: 9,18666270017)
Net ID:	Enter **PAMP**. Enter this field exactly as shown because the value is case sensitive.

Net Password:	Enter **pamopds**. Enter this field exactly as shown because the value is case sensitive.
ATT Menu:	Enter **3**.
Production Test Indicator:	Choose **P** for "Production" from the drop down box.

Step 6.1 Choose **Batch Transmit** (screen under Transaction Type) to configure the Batch Transaction Carrier. Use this particular transaction type to submit a batch of claims or requests.



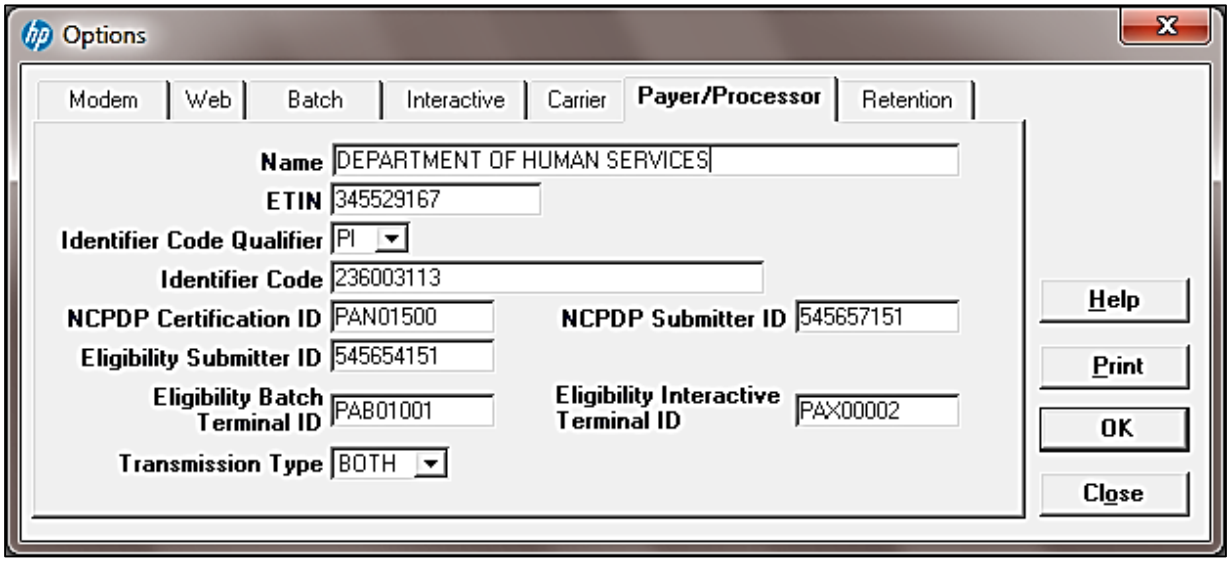
DTR:	Do not change this Value. Will automatically populate.
Carrier ID:	Select **BTCH_TOLL_FREE** from the drop down list.
Phone Number:	Automatically populates when the **Carrier ID** is selected. If you need to dial an access code prior to accessing an outside line, enter that number followed by a comma prior to the phone number. (Ex: 9, 18666270015).
Net Id:	Automatically populates with **PAMP**. Do not change this value unless directed by HP Enterprise Services. It is case sensitive.
Net Password:	Enter the value **pamopds**. Enter this value exactly as shown because the value is case sensitive.
ATT Menu:	Enter **2** in this field when testing. Not required when using the Provider Electronic Solutions (PES) software. After you

	successfully certify on Batch Transactions, change this value to **4 for production**. **Note:** PES users do not need to certify.
Production Test Indicator:	The default for this indicator is **P** since **PES users do not need to certify on Batch Transactions**, if you choose to test change this value to **T**.

5.7 Payer/Processor

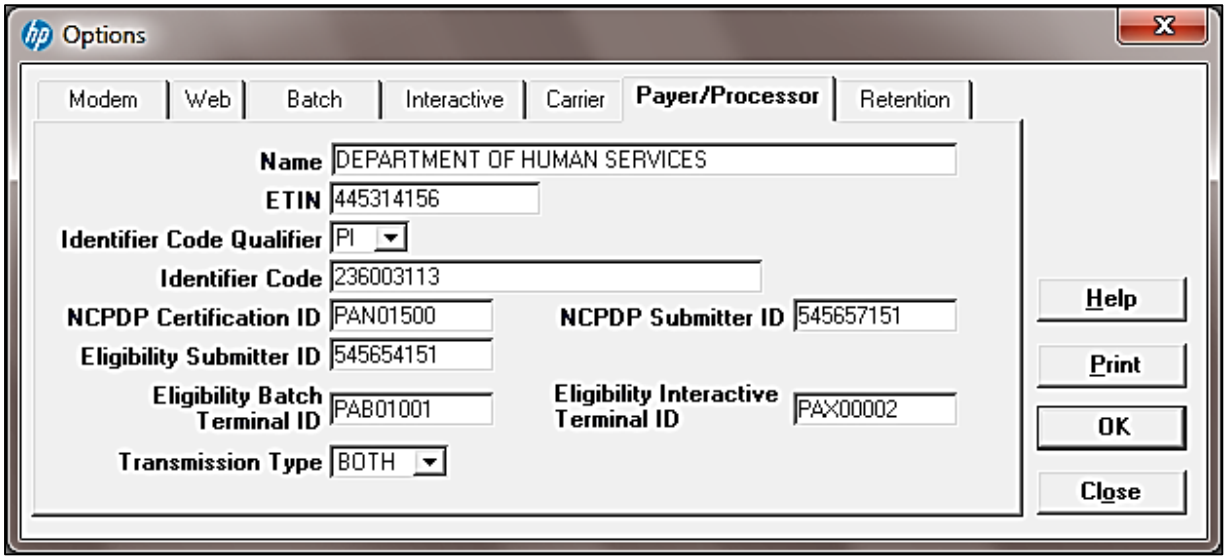
The Payer/Processor screen contains payer/processor information. To access the Payer/Processor screen:

Step 1. Click the **Payer/Processor** tab in the **Tools/Options** box.



Note: The ETIN number defaults to the production number 345529167 since **PES users do not need to certify.**

Note: This screen automatically populates, and should not be altered unless directed by HP Enterprise Services or DHS.

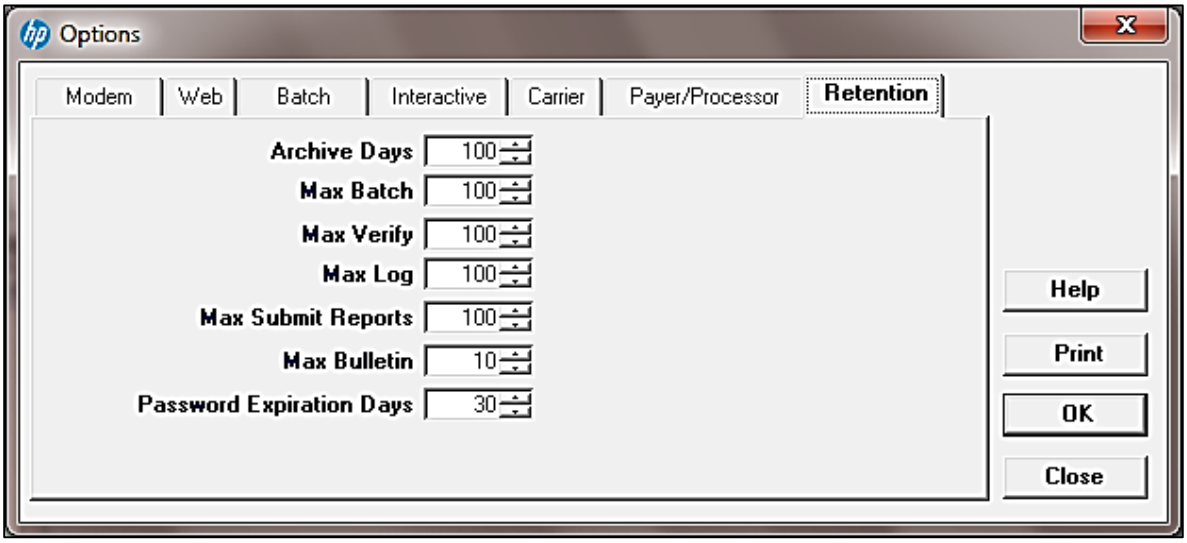


Note: This ETIN number 445314156 above is used only if you choose to certify and should not be altered unless directed by HP Enterprise Services or DHS.

5.8 Retention

The Retention screen contains settings for the length of various software functions. To access the Retention screen:

Step 1. Click the **Retention** tab in the **Tools/Options** box.

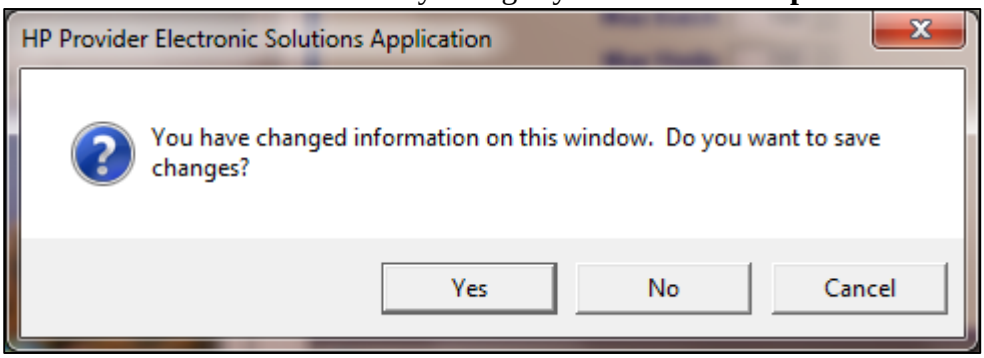


Recommended settings for the fields listed below are populated automatically. However, any setting can be changed at your discretion.

Archive Days	Number of days finalized forms are retained. After the selected number of days occurs, you are prompted to archive your invoices. All claims older than the specified number of days are archived. Invoices can be archived at any time by selecting the **Tools** menu from the main screen of the Provider Electronic Solutions software, choosing the **Archive** option, then clicking on **Create**. Archived files can also be restored, if needed. Only invoices in a finalized status are archived. Invoices in an Incomplete status are deleted. Invoices in Ready status remain untouched. The default setting for this option is 100 days; the maximum is 999.
Max Batch	Total number of batches retained in the Resubmission option of the Communications menu. The default number of batches to retain is 100; the maximum is 999. The Resubmission option of the Communications menu lets you view the batches that were sent to HP Enterprise Services and identifies the forms sent within that batch.

Max Verify	Number of 835 Electronic Remittance Advices, 271 Eligibility Responses and NCPDP Pharmacy Claim responses maintained in the View Batch Response/835 ERA (electronic remittance advice) option of the Communications menu. Downloaded files are deleted on a first in, first out basis. The default number of files to maintain is 100; the maximum number is 999.
Max Log	Number of communication log files maintained in the View Communication Log option of the Communications menu. The default number of files to maintain is 100; the maximum is 999.
Max Submit Reports	Maximum number of submission reports stored in the View Submit Reports option of the Communications menu. The default number of stored files is 100; the maximum is 999. The View Submit Reports option lets you view the forms in a particular batch if they have passed the first level of HIPAA edits.
Max Bulletin	Maximum number of bulletins stored in the View Bulletin option of the Communications menu. The default number of files to maintain is 10; the maximum is 999. Bulletins are messages that can be downloaded using the Submission option of the Communications menu. Bulletins can be viewed by accessing the View Bulletin option of the Communications menu.
Password Expiration Days	Number of days before your password expires. After the allotted number of days, you are prompted to change your password. The default number of days for a password to expire is 30; the maximum is 99. You can change your password at any time by accessing the Change Password option of the Tools menu.

Step 2. Click OK to save any changes you made to the **Options** box.


HP Provider Electronic Solutions Application
You have changed information on this window. Do you want to save changes?
Yes
No
Cancel

Step 3. Click Close to exit the **Options** box.

6 System Navigation

Navigating through the Provider Electronic Solutions software is similar to other Windows™ applications. The navigation options available are Menus, Toolbar icons, and Command buttons. Use your mouse and keyboard to access these options. On the keyboard, you have Hot Keys (such as the Ctrl + C combination, used to copy text) and Function Keys (such as the F5 key to refresh data), in addition to normal navigation keys such as Enter and Backspace. The following sections describe these navigational features in greater detail.

6.1 Using the Mouse

Using a mouse in the Provider Electronic Solutions software is the same as in most other software applications. Just move the mouse pointer to the position on the screen where you want to work or select an option. Click the left mouse button once to position your cursor at that location or to select an option.

To double-click on a feature, press the left mouse button twice very quickly. For Windows™ users, use the right mouse button to display a menu of options such as Cut, Copy, Paste, and Select All. To use the right mouse button, position the cursor on a data entry field then click and hold the right mouse button. This displays a list of options next to the field. Drag the arrow down the list until the desired option is highlighted; then release the mouse button to activate that option.

6.2 Using the Keyboard

Use the following keys to navigate through a screen using just the keyboard:

Tab or **Enter**:	Go to the next field
Shift+**Tab**:	Go to the previous field
Left Arrow:	Move backward within a field
Right Arrow:	Move forward within a field
Up Arrow:	Scroll up through a list
Down Arrow:	Scroll down through a list
F1:	Open on-line help when the cursor is on a data entry field

6.3 Menu Options

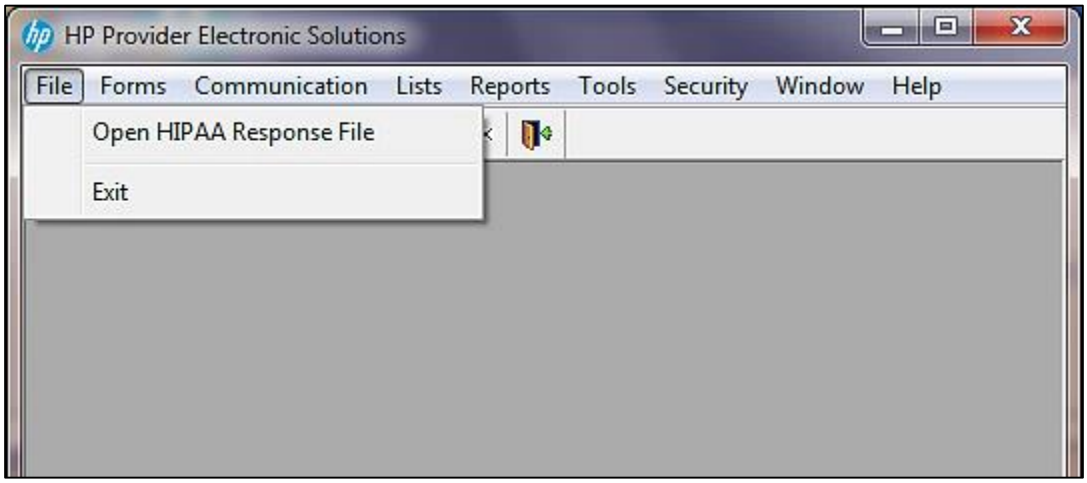
The Provider Electronic Solutions software uses drop down menus to navigate through the application and to complete data entry fields. The menu options change depending on what you are doing. When you first open the Provider Electronic Solutions software, the Main Menu is displayed. Use these menus by clicking on them with the mouse or by activating a menu option with a "hot key."

A hot key is usually a two-key combination that is pressed at the same time. For example, to view the **File** drop down menu from the Main Menu, hold the **Alt** key and then press the **F** key on your keyboard. A hot key is identified on a menu by an underlined letter (for example, the **F** in **File)**. That underlined letter is pressed in combination with the **Alt** key to access the menu option.

The options on the Main Menu bar are described below:

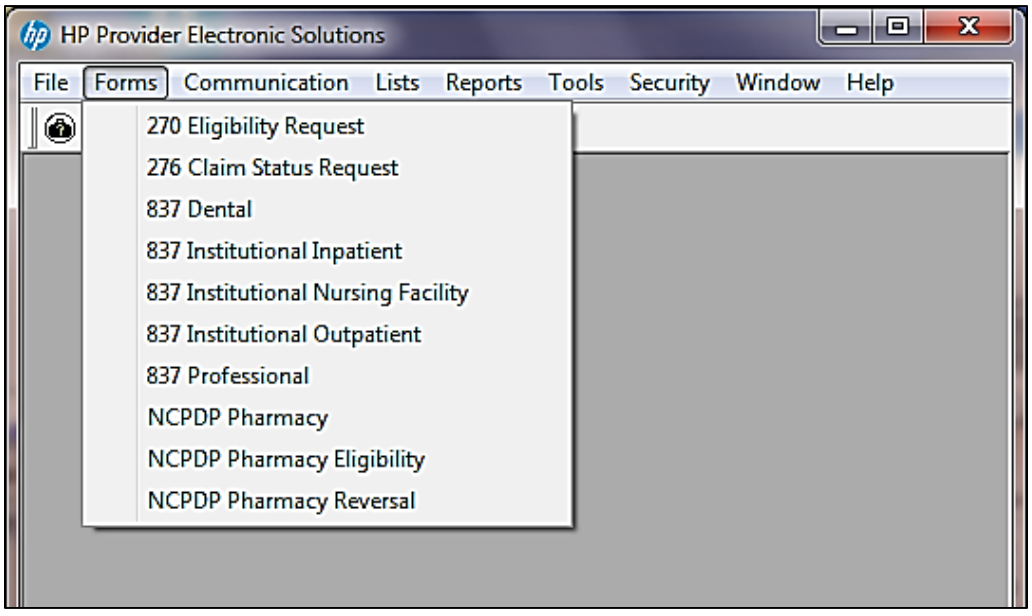
6.3.1 File

The **File** option lets you exit the application. If you have a form open, the application requires you to close the form before you exit the application.



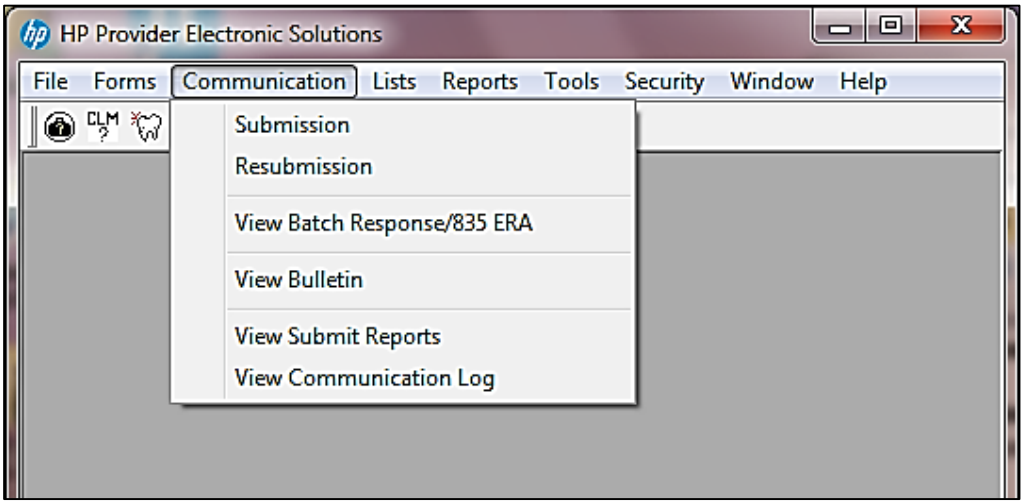
6.3.2 Forms

The **Forms** option lets you select an on-line form. You can also click the appropriate short-cut icon to access the forms.



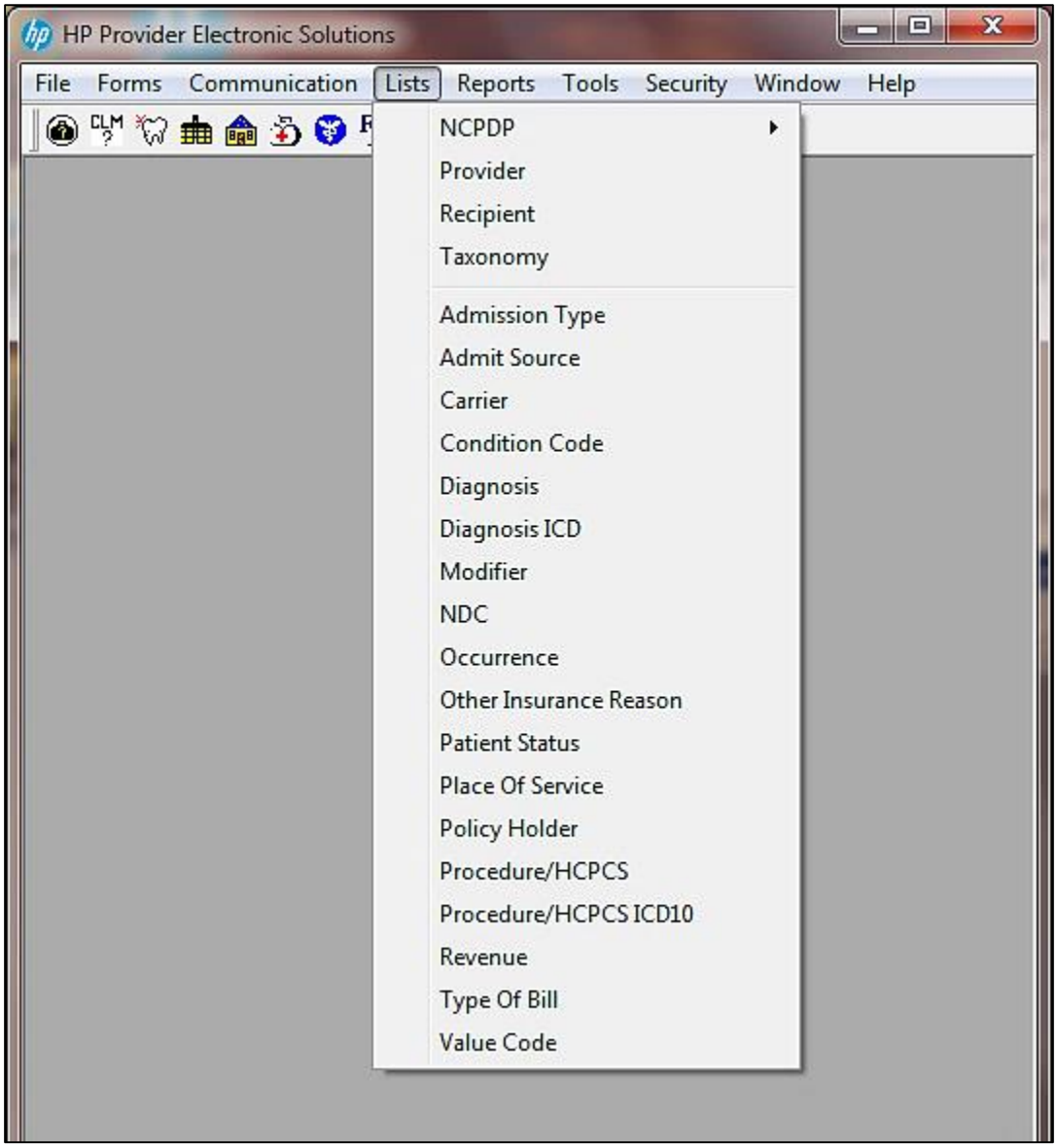
6.3.3 Communication

The **Communication** option lets you submit batches of forms and process batch responses, resubmit batches of forms, and view Communication Log files.



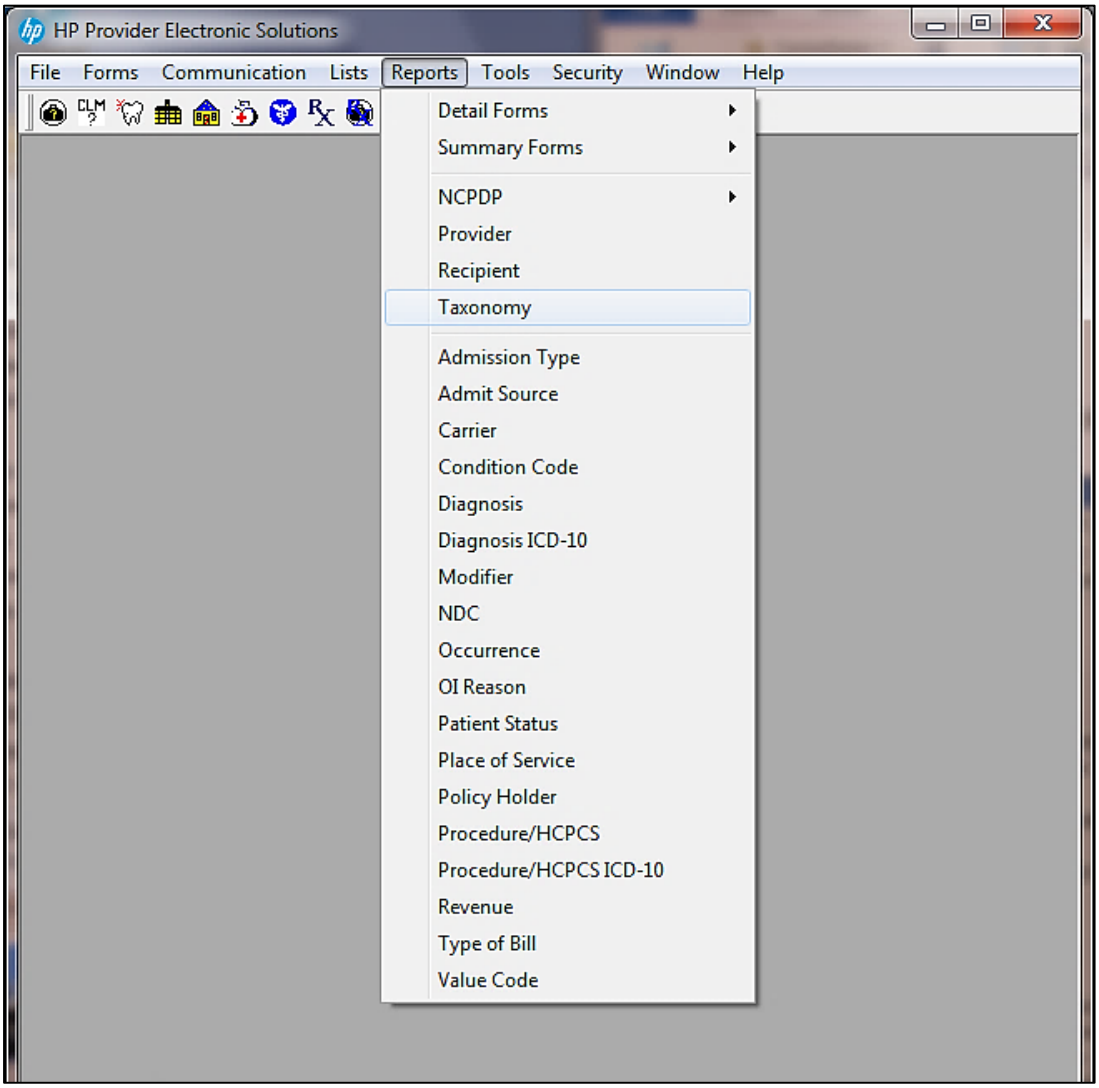
6.3.4 Lists

The **Lists** option lets you add and edit reference lists. Reference lists are customized drop down lists that you create, from which information is selected to complete data entry fields. You can access reference lists by using the **Lists** option or by double-clicking on a data entry field that is linked to a reference list.


HP Provider Electronic Solutions
File
Forms
Communication
Lists
Reports
Tools
Security
Window
Help
NCPDP
Provider
Recipient
Taxonomy
Admission Type
Admit Source
Carrier
Condition Code
Diagnosis
Diagnosis ICD
Modifier
NDC
Occurrence
Other Insurance Reason
Patient Status
Place Of Service
Policy Holder
Procedure/HCPCS
Procedure/HCPCS ICD10
Revenue
Type Of Bill
Value Code

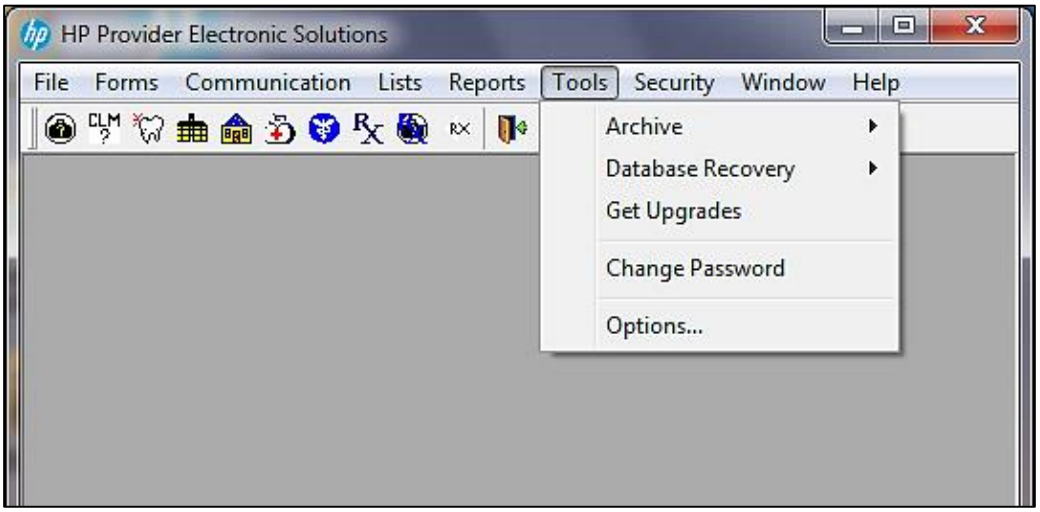
6.3.5 Reports

The **Reports** option lets you create and print summary or detail reports of the forms or reference lists.



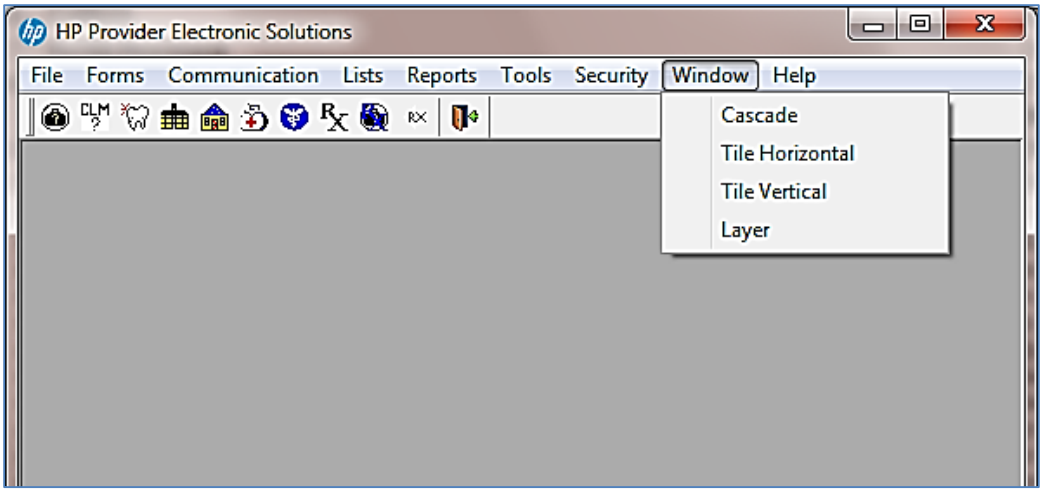
6.3.6 Tools

The **Tools** option lets you create and work with archives, perform database maintenance, retrieve upgrades, set up communications options, and determine retention settings.



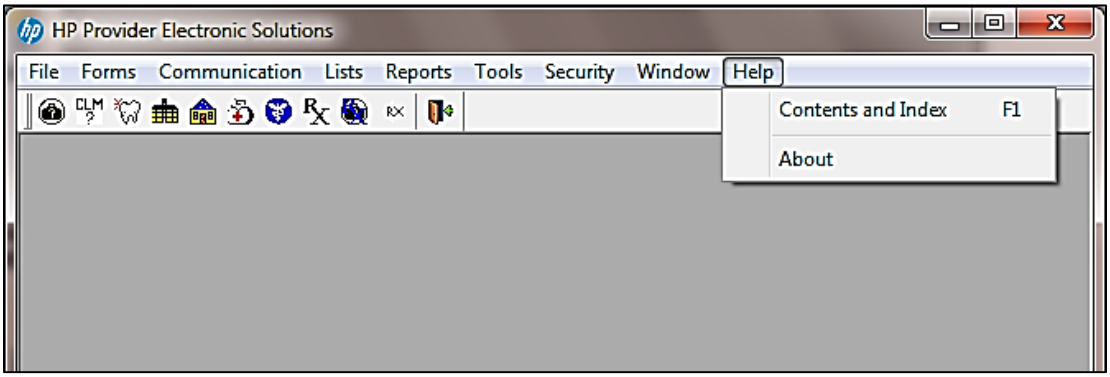
6.3.7 Window

The **Window** option lets you access the standard options available for most Windows™ compatible applications. These options help you to configure the appearance of your work area.



6.3.8 Help

The **Help** option lets you access the help file and basic information about the Provider Electronic Solutions software such as copyright details and version information.

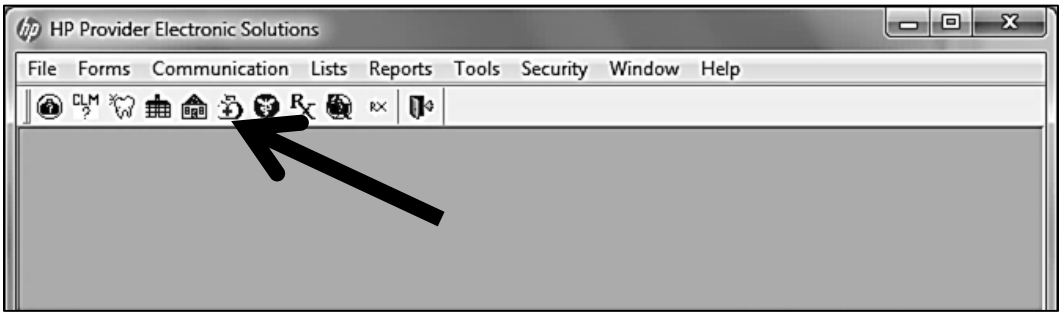

HP Provider Electronic Solutions
File Forms Communication Lists Reports Tools Security Window Help
Contents and Index F1
About

6.3.9 Toolbar Shortcut Buttons

Toolbars are designed to work as shortcuts for frequently used menu commands and to reduce the time and steps needed to activate a function. A toolbar consists of small pictures or shortcut icons that represent different menu commands. To execute a command using the toolbar, simply click on the appropriate shortcut icon with the mouse. To see a name or brief description of each shortcut icon, move the mouse arrow over the icon (hover) but do not click the mouse. The description will appear just below the shortcut icon at which you are pointing.

The Toolbar on the Provider Electronic Solutions software Main Screen is shown below:

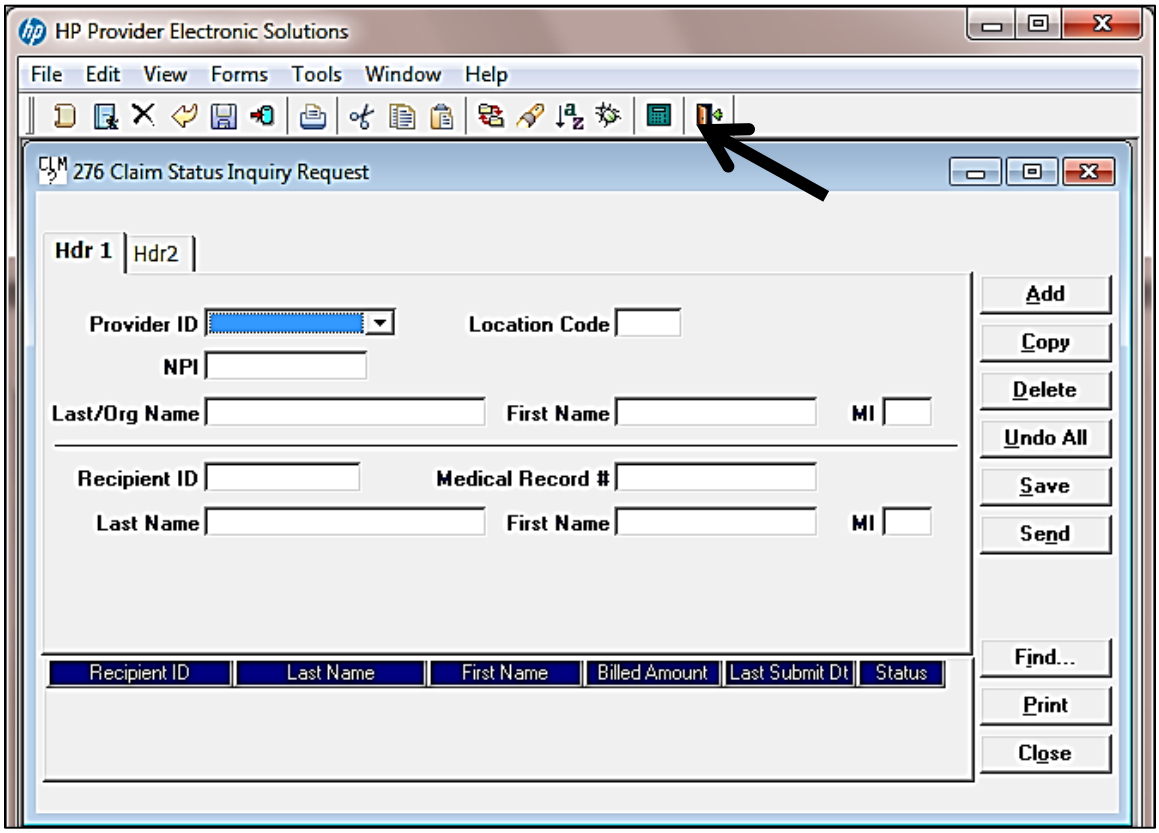
The location of the Toolbar on the Provider Electronic Solutions software Main Screen is shown below:



The shortcut icons on the Provider Electronic Solutions software main screen toolbar are described here:

Icon	Shortcut Button Name	Description
	270 Eligibility Request	Calls the 270 Eligibility Request Form.
	276 Claim Status Inquiry	Calls the 276 Claim Status Inquiry Form.
	837 Dental Shortcut	Calls the 837 Dental Form.
	837 Institutional Inpatient	Calls the 837 Institutional Inpatient Form.
	837 Institutional Nursing	Calls the 837 Institutional Nursing Home Form.
	837 Institutional Outpatient	Calls the 837 Institutional Outpatient Form.
	837 Professional	Calls the 837 Professional Form.
	NCPDP Pharmacy	Calls the NCPDP Pharmacy Form.
	NCPDP Pharmacy Eligibility	Calls the NCPDP Pharmacy Eligibility Form.
	NCPDP Pharmacy Reversal	Calls the NCPDP Pharmacy Reversal Form.
	Exit	Closes the Provider Electronic Solutions software.

Note: The toolbar on the various forms is different from the toolbar on the Provider Electronic Solutions software main screen. The toolbar on the various form windows is shown here and on the next screen shot:



Shortcut icons on the forms toolbar are explained here:

Icon	Shortcut Form Name	Description
	Add Form	Saves the existing form and calls up a new blank form.
	Copy Form	Makes a copy of the existing form.
	Delete Form	Deletes the existing form.
	Undo All	Reverses all of the changes done to the existing form since the form was last saved.
	Save Form	Saves the existing form.

Icon	Shortcut Form Name	Description
	Send Form	Transmits the existing form for processing.
	Print Form	Can only be accessed from one of the various form screens. Selecting the print icon will automatically create a report and lets you print the report that was automatically created.
	Cut	Deletes the highlighted data and places a copy of the data on the clipboard so that it can be pasted into another field or software program.
	Copy	Copies the highlighted data to the clipboard so that it can be pasted into another field or software program.
	Paste	Inserts data from the clipboard to the selected data fields or another software program.
	Filter	Lets you define which forms are displayed at the bottom of the form screen by status, date submitted, name, amount billed, etc.
	Find	Lets you search for a claim by recipient ID, last name, first name, and billed amount.
	Sort	Lets you sort the claims that are displayed at the bottom of the form screen by recipient ID, last name, first name, billed amount, status, and submit date.
	Errors	Lets you view errors that have been detected on the current form.
	Calculator	Calls up the calculator.
	Exit	Closes the form.

6.3.10 Command Buttons

Command buttons are navigation shortcuts that appear on the various Provider Electronic Solutions software screens. You can activate command buttons by clicking on them with a mouse or using the hot key associated with that button.

The hot key is identified on a menu by an underlined letter, which works simultaneously with the Alt key on your keyboard.

The major command buttons are:

Button	Button Name	Description
Add	**Add**	Adds a new claim or a selection to a reference list.
Copy	**Copy**	Copies the current claim. Copied information appears in the data entry screen. **Note:** The original claim is not altered by any changes made to the copy.
Delete	**Delete**	Deletes the current claim or reference list selection. You are prompted to confirm the deletion. Click the **Yes** Button to delete the claim or reference list selection.
Undo All	**Undo All**	Reverses all changes made to the current claim or reference list selection since the last time you saved the claim or reference list selection.
Save	**Save**	Saves data entered in the current claim or reference list selection. When saving a claim or reference list selection, the data is evaluated or edited for completeness. If the data is determined to be incorrect, a list of errors is presented for correction. After you save a claim or reference list selection, the claim or reference list selection status is updated and displayed in the lookup window, located at the bottom of the form window.
Send	**Send**	Send button utilizes the Interactive Submission functionality. An interactive submission is when a single request is entered and a response is received back within a few minutes after the request is submitted.
Find...	**Find**	Locates specific claims or a reference list selection from the list in the lookup window.

Print	**Print**	Creates a report of the current claim or reference list selection and displays it. When the report is displayed, you can either view or print it.
Close	**Close**	Closes the form. If you made changes to the current claim or reference list, you are prompted to save those changes before leaving the form or reference list.

7 Reference Lists

A reference list is a drop down list that you build. As with any drop down list, a reference list contains selections that can be used to complete data entry fields. However, a reference list is unique because you add the selections to the list.

After you have added your selections to a reference list, you can access the selections in that list to quickly complete data entry fields of the form you are completing.

For example, if your office has three providers, you are required to enter provider information, such as MPI, location code, provider name, Taxonomy Code, NPI (National Provider Identifier) and provider address (Including the Nine-Digit Zip Code) for each form completed. Entering the same information for multiple providers each time you complete a form is very time consuming.

The Provider reference list solves this dilemma by letting you enter and save information for each provider as a selection in a drop down box. Once you have added the selection to the Provider reference list, you can choose that selection when you create a form and the information contained within that selection will automatically populate the form fields.

References lists speed the data entry process and help ensure the accuracy of information used to complete the forms.

Reference lists can be built or edited by anyone using the software.

Reference lists can be built or used four different ways. You can choose one of the following options for building your Reference lists:

1. Build your reference lists prior to accessing a form, which is helpful for lists that are used often and contain information within the selections that rarely changes, such as the Provider reference list.
2. Build a reference list “as you go”, (while completing a form), which is helpful for lists that contain information within selections that may not be used often, such as the Recipient reference list.
3. Complete some of the data entry fields manually, rather than saving selections to a reference lists. Temporarily entering the information in a data entry field and not saving it to a reference list is beneficial when you are familiar with the data needed to complete the field or in cases where the data changes often. Some of the reference lists that you may want to complete temporarily are the Diagnosis/Diagnosis ICD and Procedure/HCPCS and Procedure/HCPCS ICD10 reference list.
4. Use the reference lists, i.e., Place of Service and Patient Status reference lists, which are already built for you and preloaded during the installation process. These pre-loaded selection lists can still be edited and additional selections added.

Accessing, building, and editing reference lists is discussed in more detail, later in this section.

This chart helps to determine when and how to build your reference lists for the forms you need to complete. Although the chart provides suggestions on when to build a reference list, keep in mind you need to choose the method for building reference lists that best suits your needs.

Form	Reference List			
	Prior	**"As you go"**	**Temporary**	**Preloaded**
270 Eligibility Request	Taxonomy (270 Provider)	Recipient ID		
837 Dental	Provider Location Code	Recipient ID Policy Holder Modifiers	Procedure/HCPCS Procedure/HCPCS ICD10	Place of Service
837 Institutional Inpatient	Provider Location Code	Recipient ID Revenue Policy Holder	Diagnosis Diagnosis ICD Procedure/HCPCS Procedure/HCPCS ICD10	Type of Bill Patient Status Occurrence Condition Code Value Code Admission Type Admission Source
837 Institutional Nursing Facility	Provider Location Code	Recipient ID Revenue Policy Holder	Diagnosis Diagnosis ICD Procedure/HCPCS Procedure/HCPCS ICD10	Type of Bill Patient Status Occurrence Condition Code Value Code Admission Source Admission Type
837 Institutional Outpatient	Provider Location Code	Recipient ID Revenue Policy Holder	Diagnosis Diagnosis ICD Procedure/HCPCS Procedure/HCPCS ICD10	Type of Bill Patient Status Occurrence Condition Code Value Code Admission Source Admission Type
837 Professional	Provider Location Code	Recipient ID Policy Holder Modifiers	Diagnosis Diagnosis ICD Procedure/HCPCS Procedure/HCPCS ICD10	Place of Service Carrier
NCPDP Pharmacy	NCPDP Provider	NCPDP Recipient NDC	Diagnosis Diagnosis ICD	

Form	Reference List			
	Prior	**"As you go"**	**Temporary**	**Preloaded**
NCPDP Pharmacy Eligibility	NCPDP Provider	NCPDP Recipient		
NCPDP Pharmacy Reversal	NCPDP Provider			

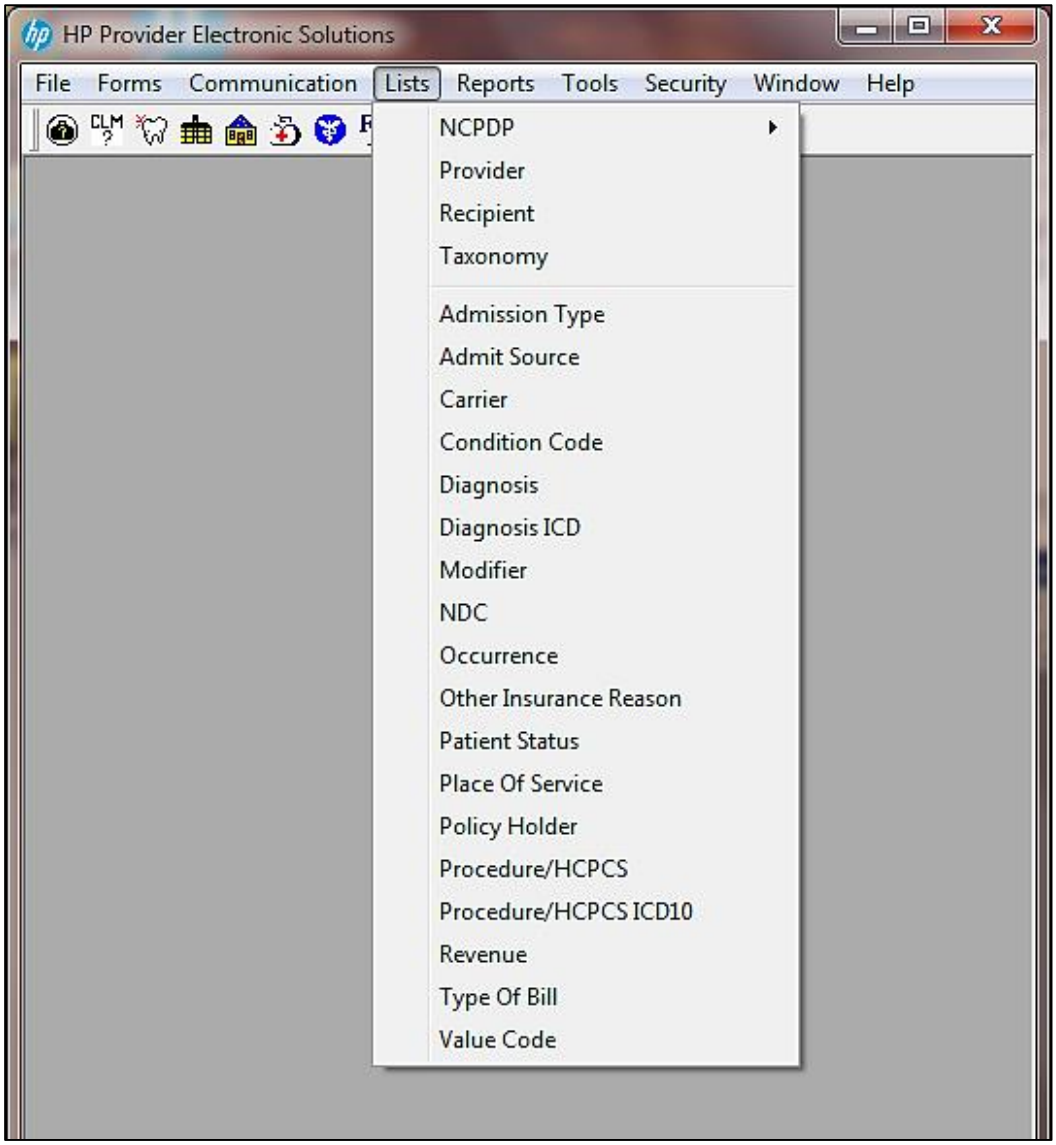
7.1 Accessing a Reference List

Reference lists are accessed by using the Lists option or by double clicking on a data entry field that is linked to a reference list.

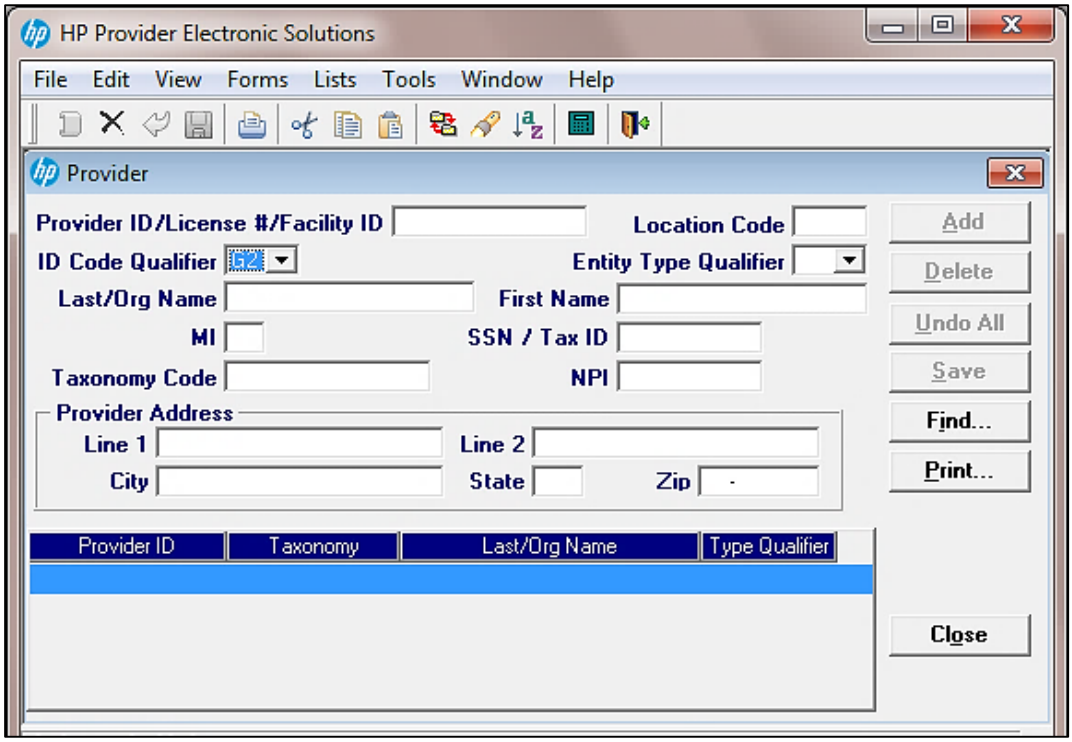
To access a reference list from the Provider Electronic Solutions software main menu, perform the following steps:

Step 1. Access the Provider Electronic Solutions software main menu.

Step 2. Select the **Lists** option and select the reference list you need.



Step 3. Select **Provider** when the reference list is displayed.

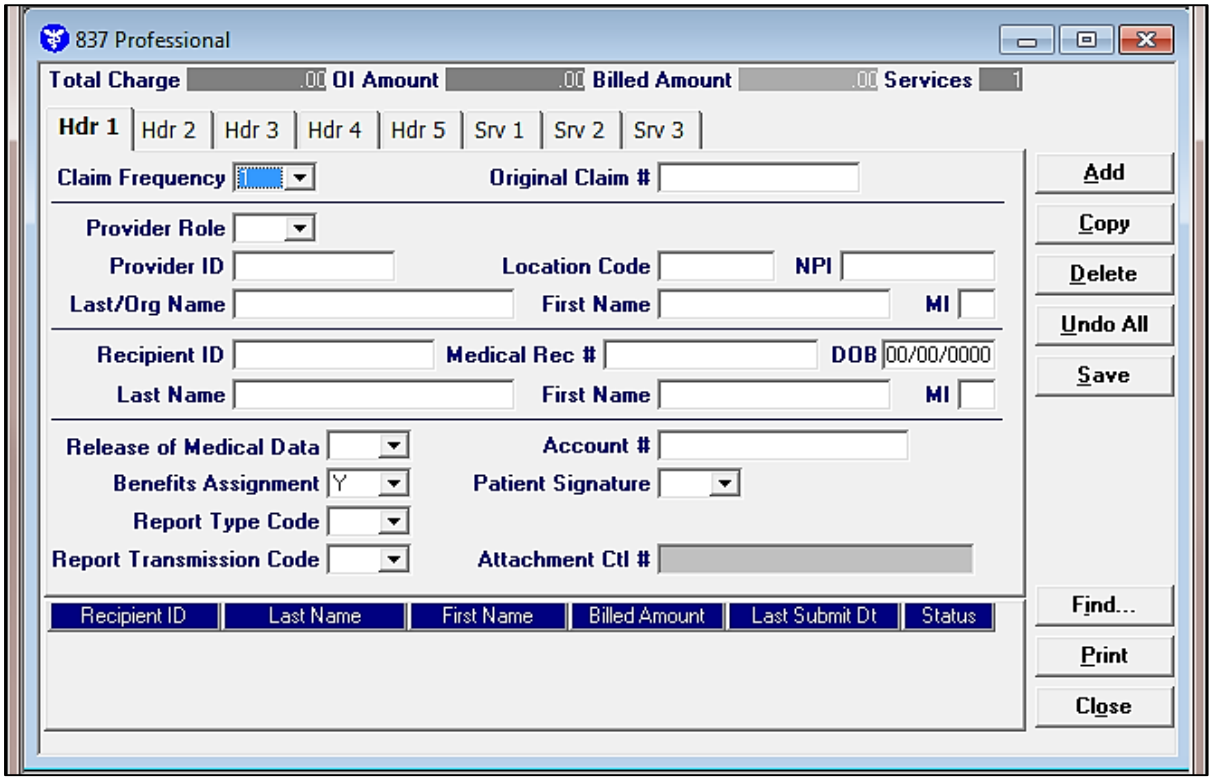


Step 3.1 Click Close to close the reference list box.

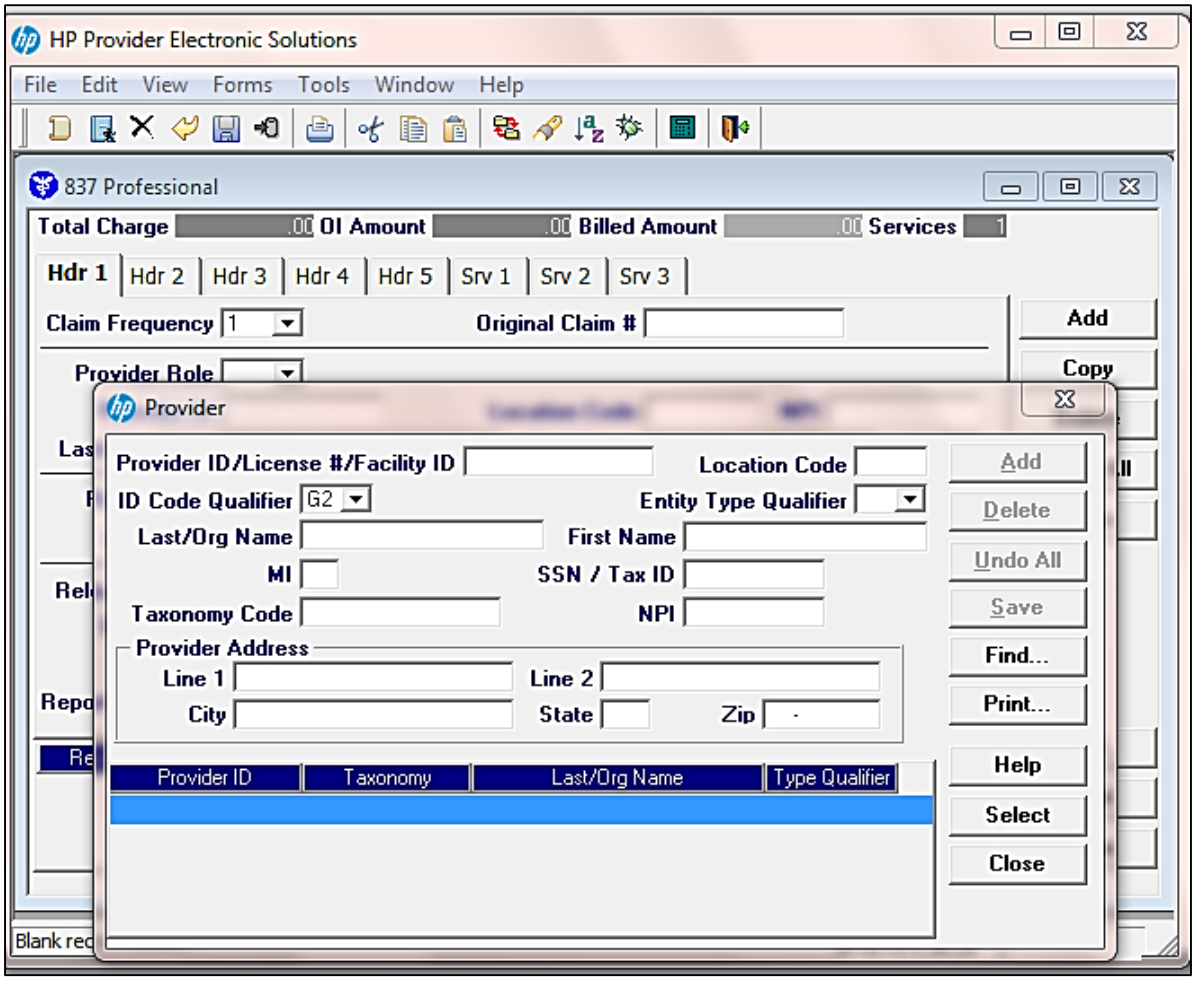
To access a reference list from a form screen, perform the following steps:

Step 1. Access a form using the **Forms** menu or short cut icon.

Step 2. Double-click the data entry field for the reference list you need. Click the **Provider ID** data entry field as shown below, to access the Provider reference list.



The Provider list box is displayed.



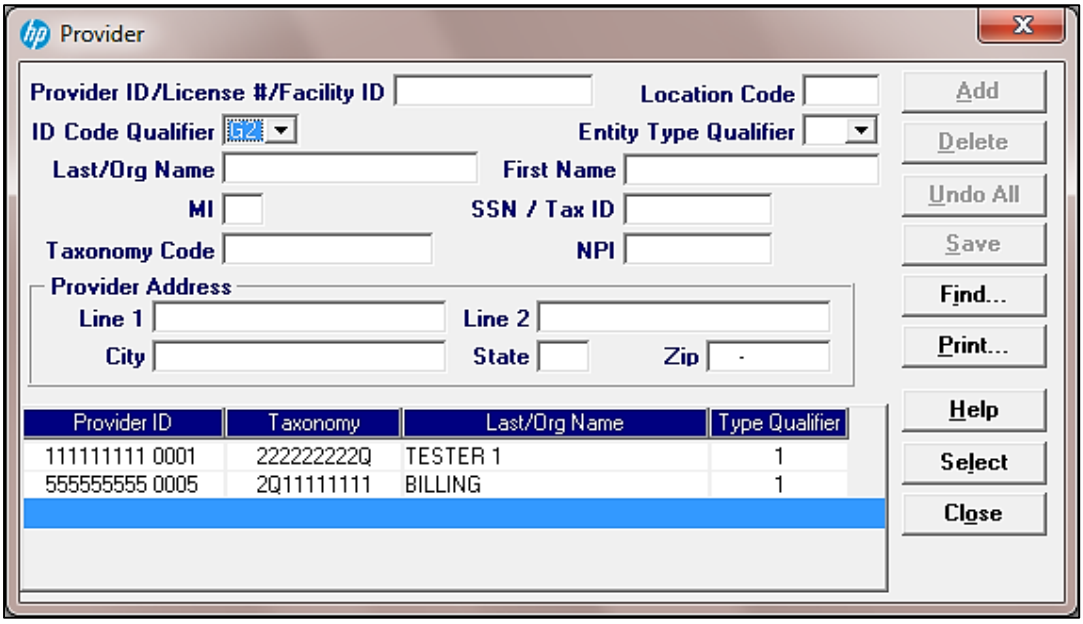
Step 3. Click to close the reference list box.

7.2 Create or Build a Reference List Prior to Accessing a Form

Step 1. Access the reference list.

Step 2. Enter the data requested for each field.

Each reference list has unique data entry fields. See Section 8 for instructions on completing data entry fields for a specific reference list.

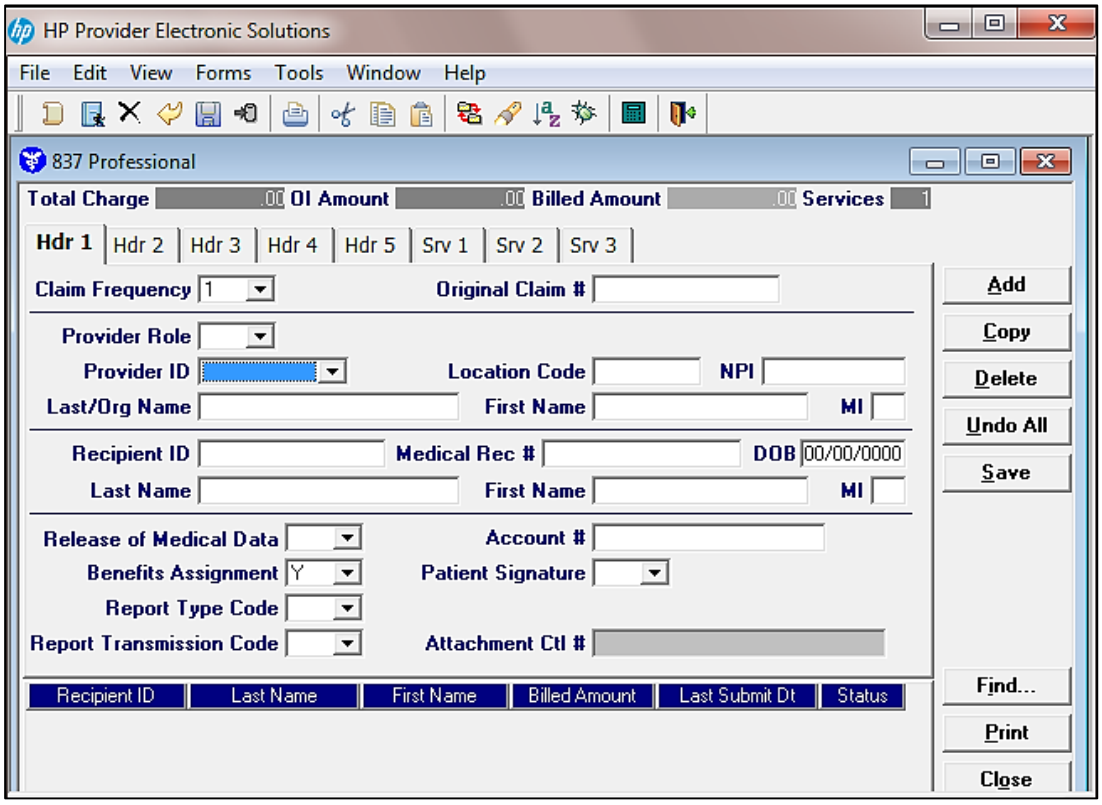


Step 3. When the data entry fields have been completed, click Save. After the selection has been saved, you can choose this selection from a drop down list to automatically populate the information above in the appropriate fields.

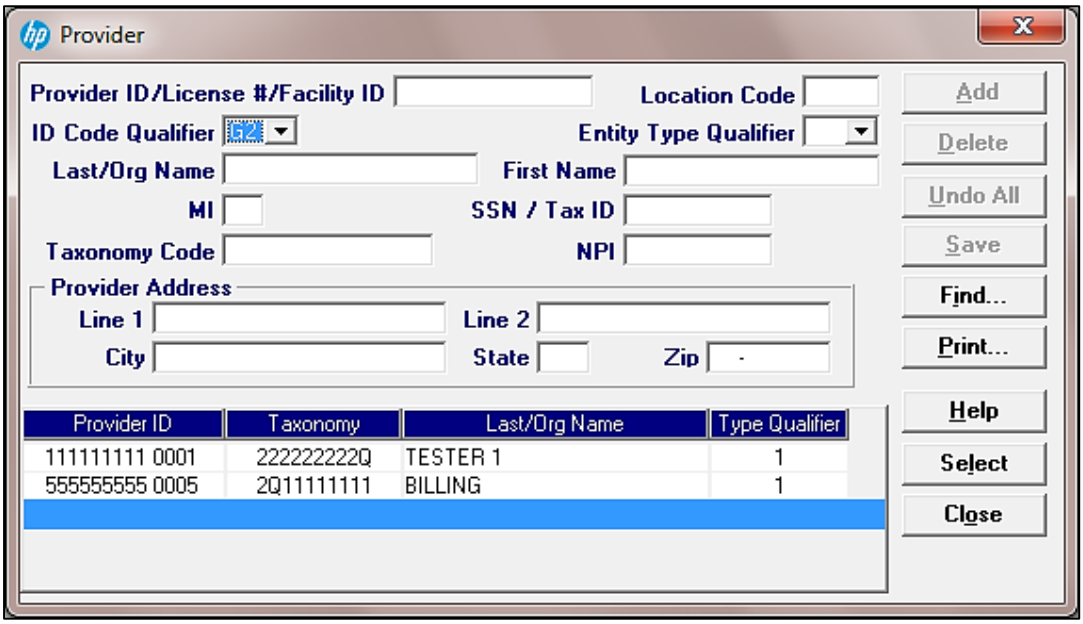
Step 4. To add another selection to the same reference list, click Add and repeat steps 1, 2, and 3, as shown above.

To create or add to a reference list "as you go" (while completing a form), perform the following steps:

Step 1. Double-click the data entry section of the field for which you would like to add a selection or create a reference list.



Step 2. Enter the data requested for each field.



Step 3. When the data entry fields are completed, click Save.

Step 4. To add another selection to the same reference list, click Add and repeat steps 1, 2, and 3 above.

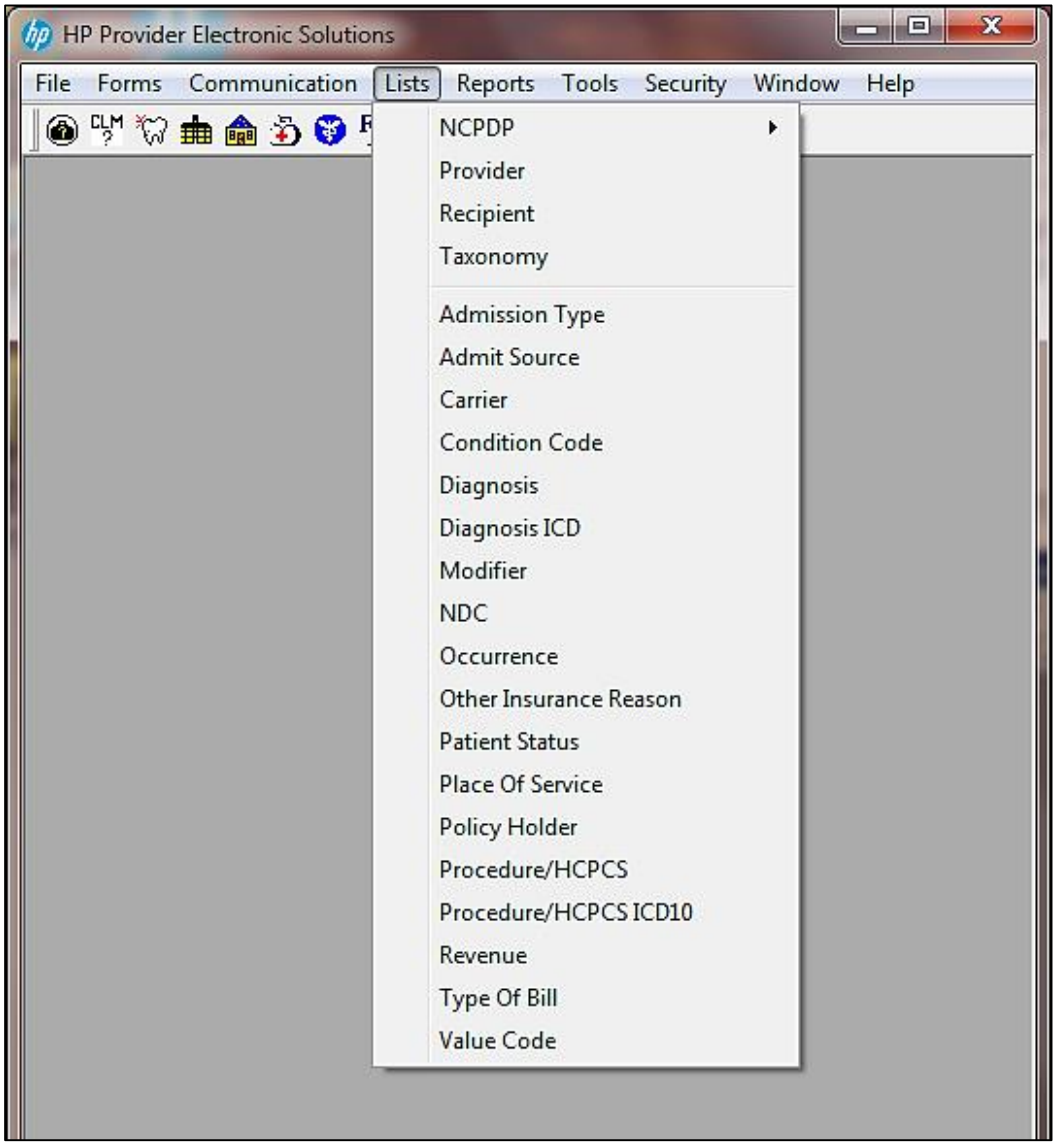
7.3 Edit/Delete a Reference List

To edit or delete a reference list selection prior to accessing a form, complete the following steps:

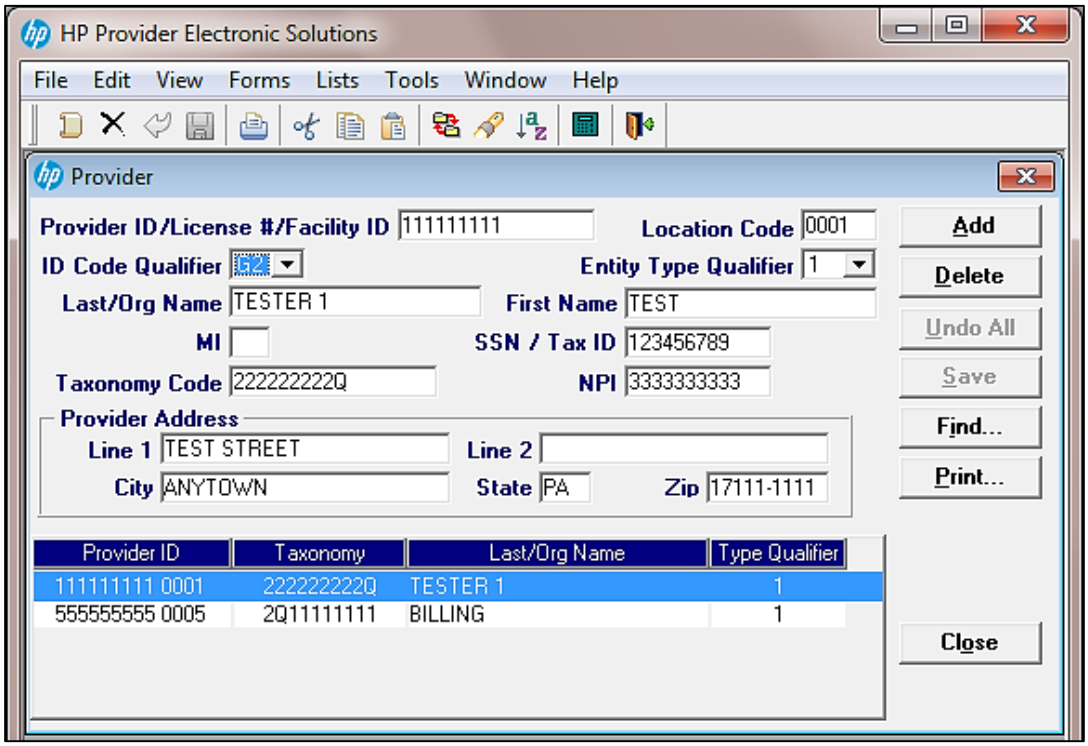
Step 1. Access the Main screen of the Provider Electronic Solutions software.

Step 2. Click the **Lists** Menu and then click on the type of list you need to edit or delete.

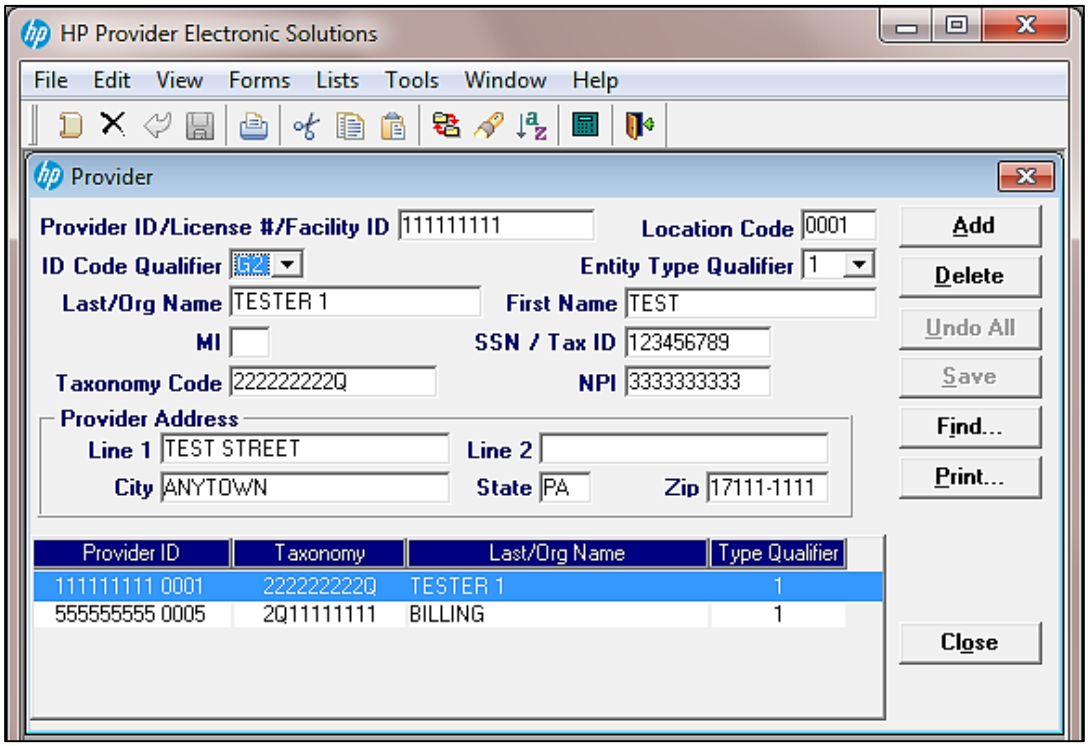
The reference list box is displayed. The selections for the reference list you have accessed are displayed at the bottom of the reference list box. Click the selection that you need to edit or delete.



The software then fills the data fields on the screen with the information for the selection.



Step 3. Tab to or click the data entry field to be edited and make the appropriate changes by typing over the already populated information.



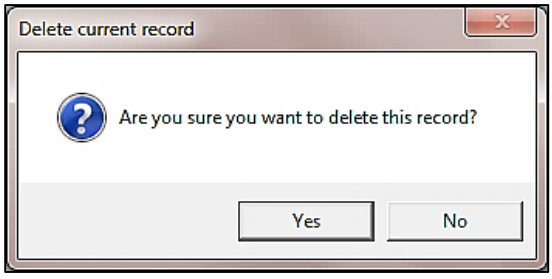
Step 4. Click Save to save your changes.

To delete a selection prior to accessing a form, perform the following steps:

Step 1. Complete steps 1, 2, and 3 as directed above.

Step 2. Click Delete.

Step 3. A box appears to ask if you are sure you want to delete the record.

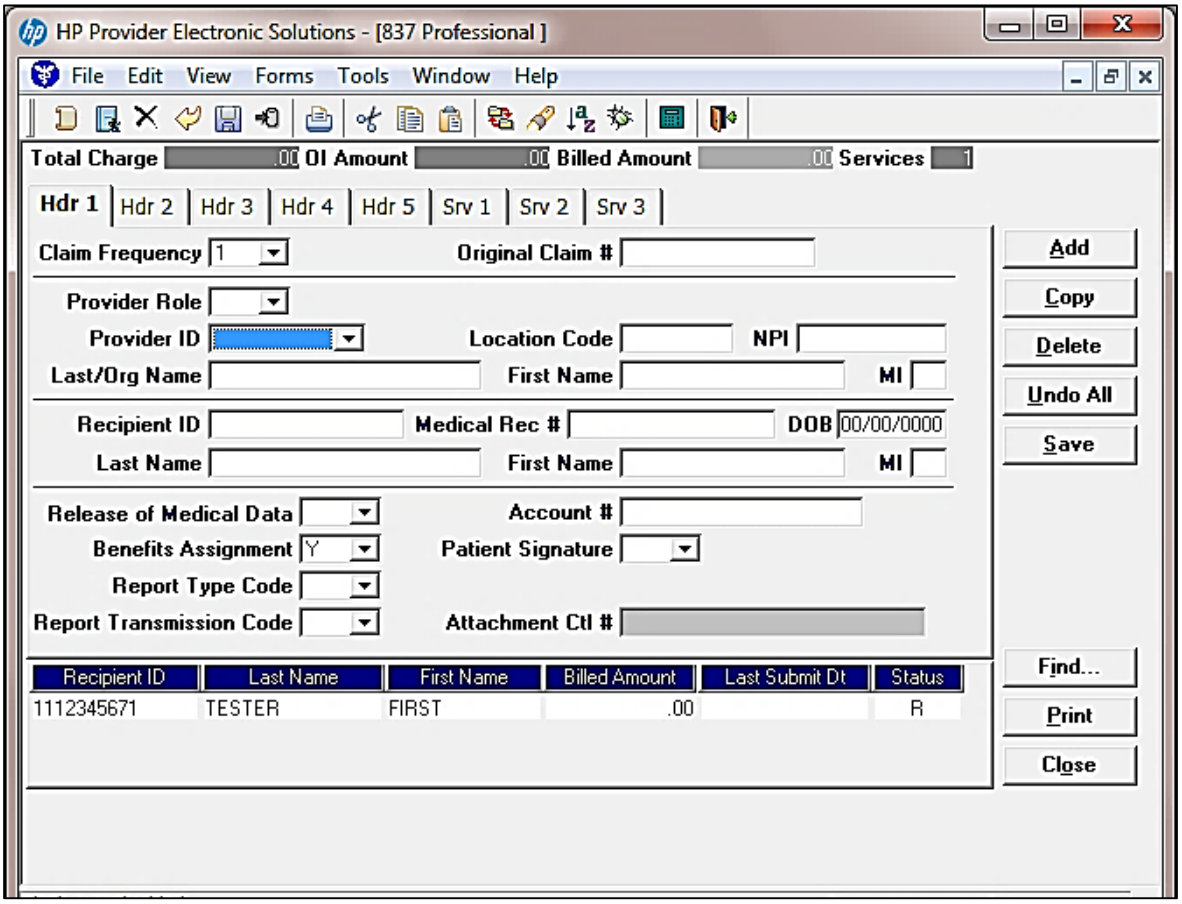


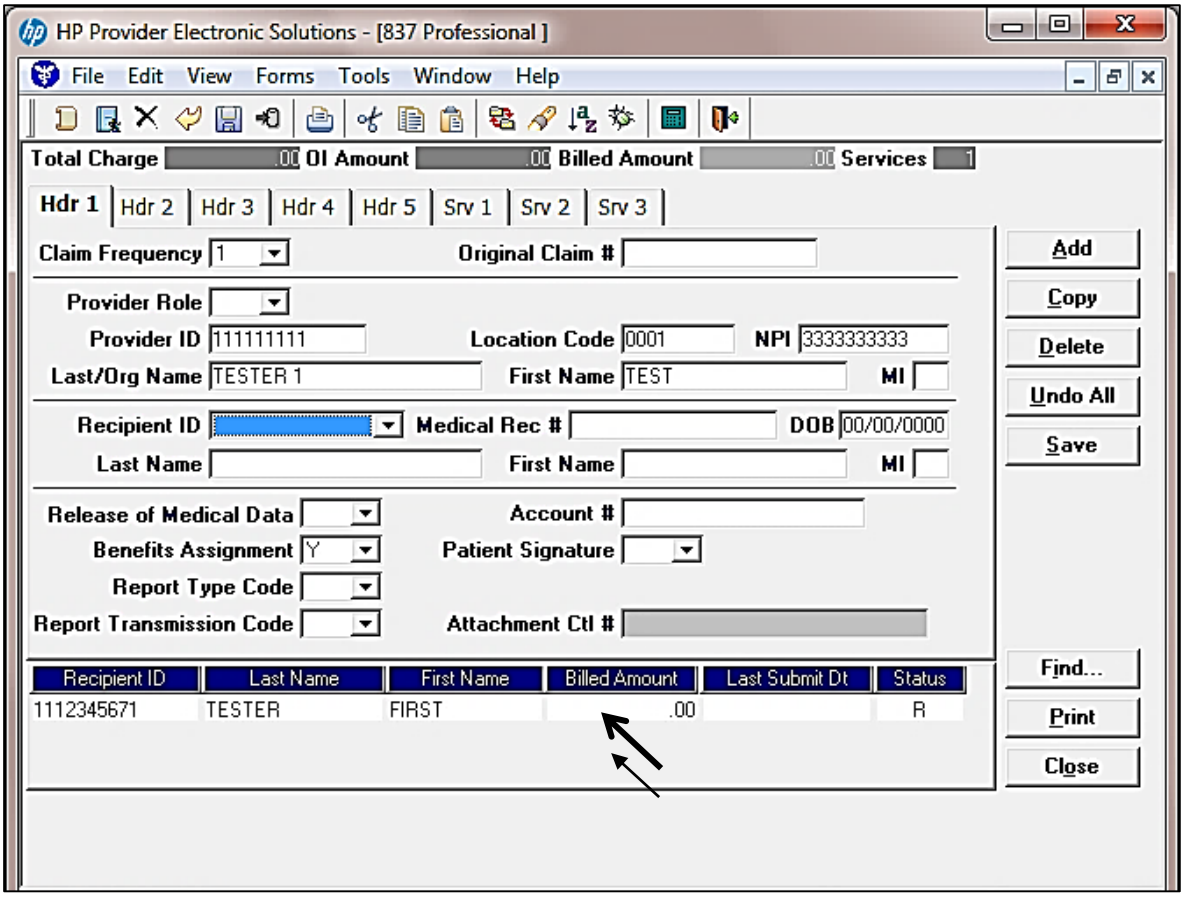
Step 4. Click Yes.

To edit or delete a selection "as you go" (while completing a claim), perform the following:

Step 1. Access the claim.

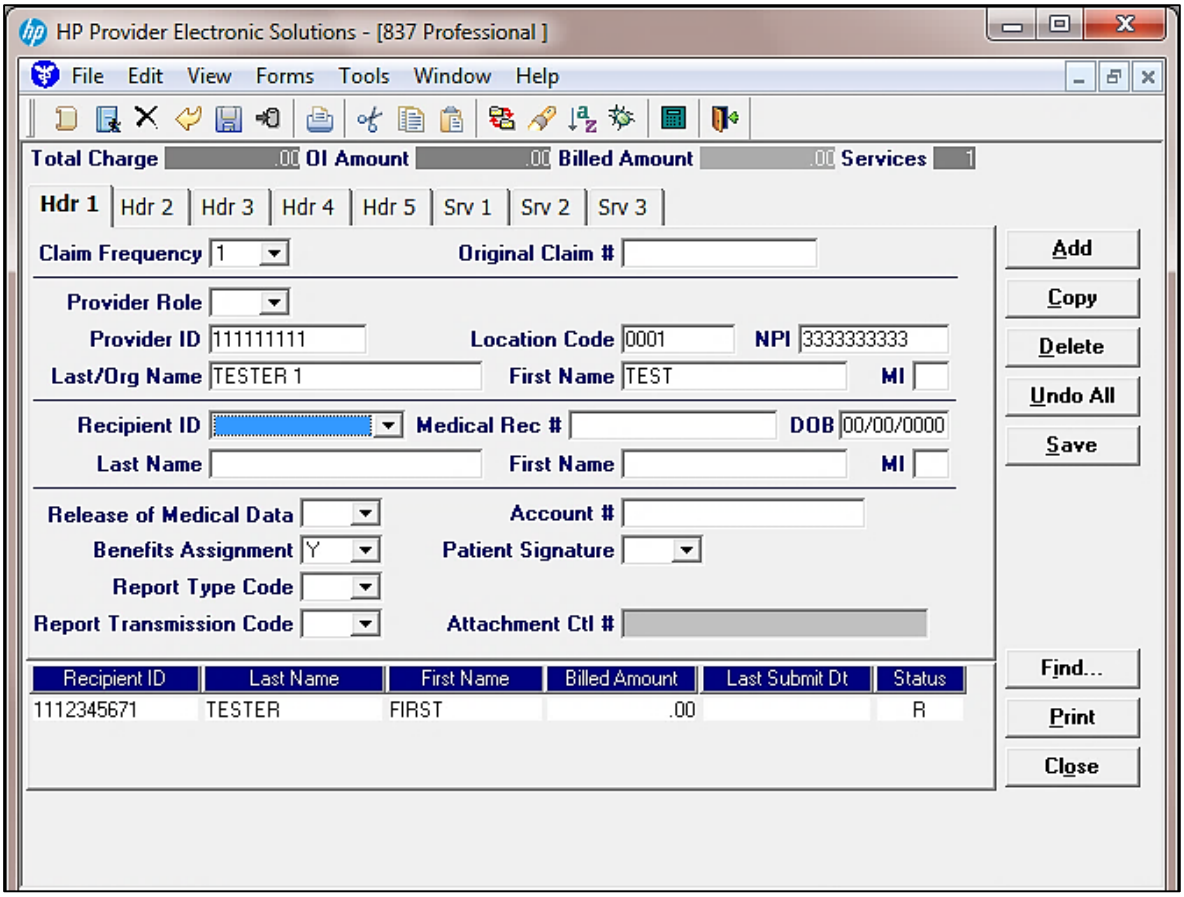
Step 2. Double-click on the data entry section of the field for the reference list you would like to change.





Step 3. Click the selection listed at the bottom of the screen that you would like to edit or delete.

Step 4. The data fields on the screen are filled with the information from the selection.



Step 5. Tab to or click on the data entry field to be edited, and make the appropriate changes by typing over the already populated information.

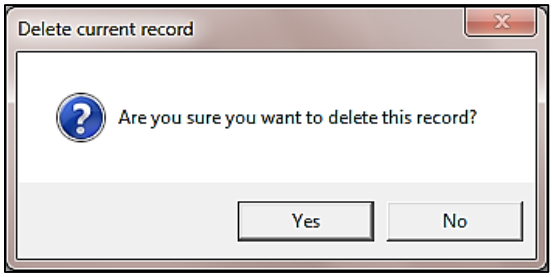
Step 6. Click Save to save your changes.

To delete a selection "as you go" (while accessing a claim), perform the following steps:

Step 1. Complete steps 1 through 4 as directed above.

Step 2. Click Delete.

Step 3. A box appears and asks you if you are sure you want to delete the record.



Step 4. Click Yes.

8 Complete a Specific Reference List

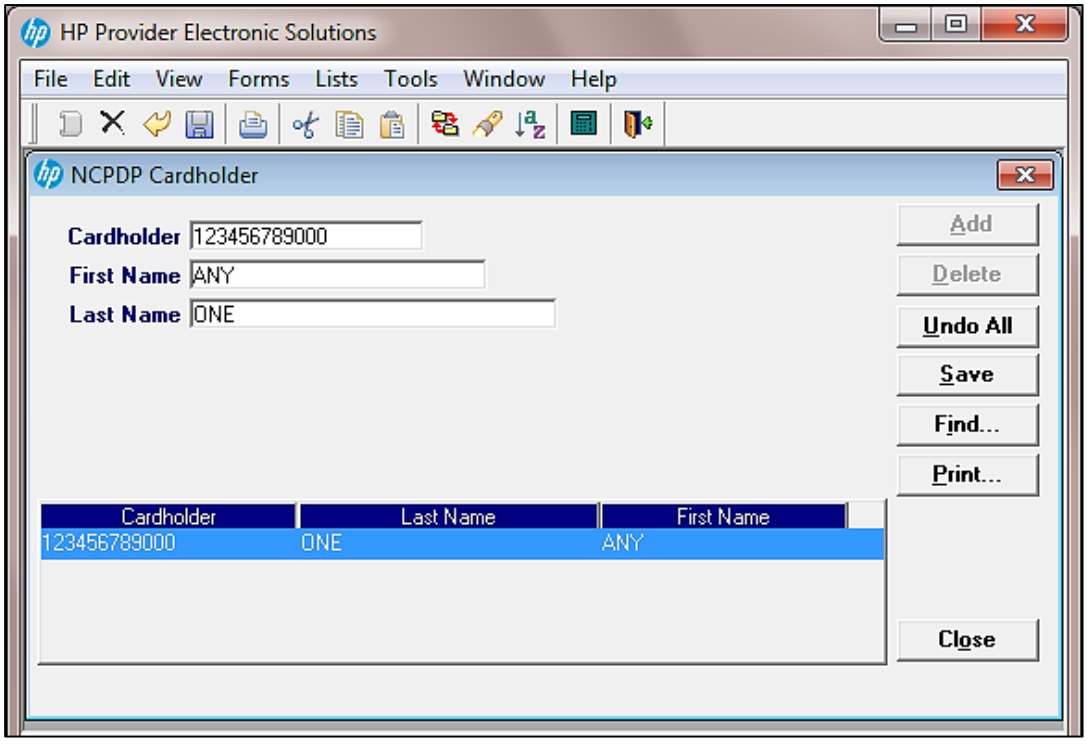
The Provider reference list is linked to the Provider ID, Referring Provider, Rendering Provider ID, and Facility ID fields. Therefore, the selections added to the 837 Provider reference list can be accessed from any of the fields mentioned above.

If a provider renders services in multiple locations or is a provider with multiple provider types, add multiple selections for that provider so that each selection properly reflects the location code for the rendered services.

8.1 837 NCPDP Cardholder Reference List

To complete the data entry fields needed to add or edit an NCPDP Cardholder reference list selection, perform the following:

Step 1. Click **Lists/NCPDP/NCPDP Cardholder** to access the NCPDP Cardholder reference list.



Step 2. Enter the data requested for each field, as described below.

NCPDP Cardholder	Enter the recipient ACCESS ID and card issue number in the following format: 10-digit ACCESS number and 2-digit card issue number [i.e., **123456789000**].
First Name	Enter the cardholder's first name.
Last Name	Enter the cardholder's last name.

Step 3. Click Save when all data entry fields are completed.

If any required fields were missed, you are prompted to complete them.

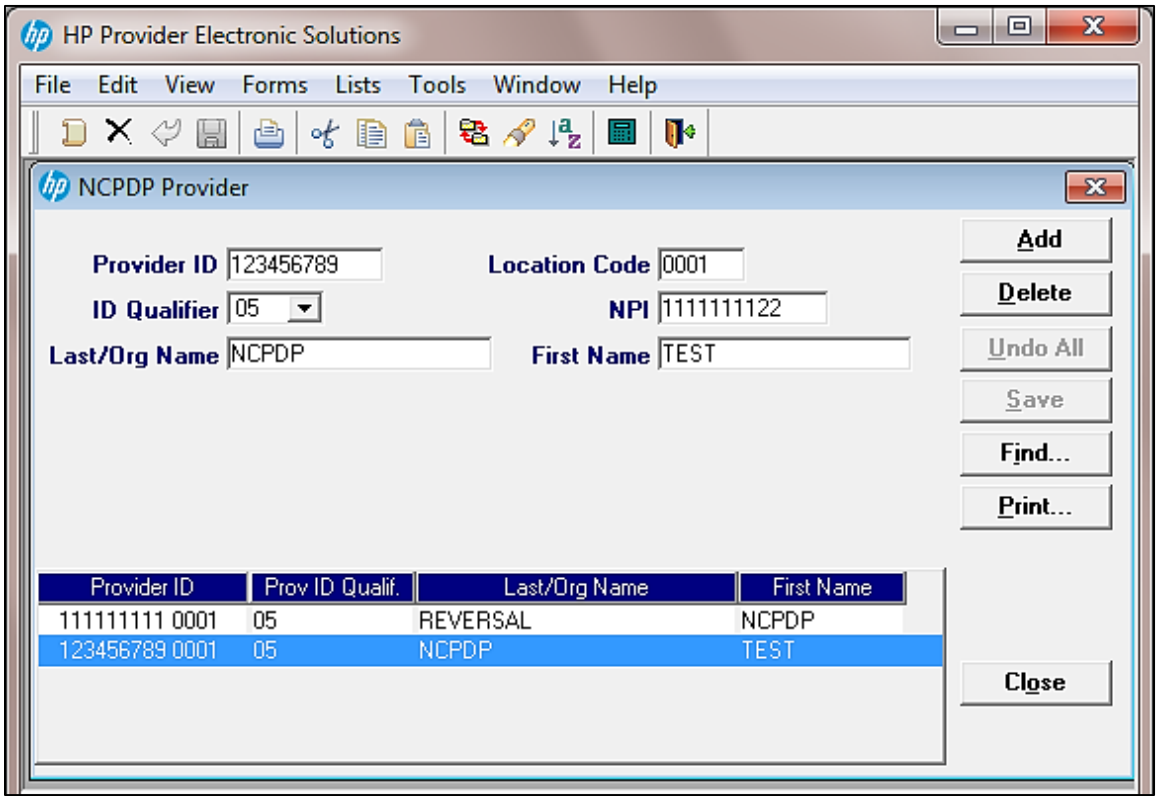
Step 4. Click Add and repeat steps 2, 3, and 4 to add another NCPDP cardholder to the NCPDP Cardholder reference list.

Step 5. Click Close to exit the NCPDP Cardholder screen.

8.2 NCPDP Provider Reference List

To complete the data entry fields on the NCPDP Provider reference list, perform the following:

Step 1. Click **Lists/NCPDP/NCPDP Provider** to access the NCPDP Provider reference list.



Step 2. Enter the data requested for each field, as described below.

Provider ID	Enter the 9-Digit MPI number assigned to you by DHS.
Location Code	Enter the 4-digit location code assigned to you by DHS for your MPI Number. If multiple location codes are assigned to a single provider number, complete multiple entries in the NCPDP Provider reference list for each location code.

ID Code Qualifier	Select one of the following values from the preloaded drop down list or enter an appropriate value as specified: **05** – Medicaid Provider Number **99** – Other **Note:** This value is submitted in the Provider ID field.
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name	Enter the last name of the MA provider, group, or facility.
First Name	Enter the MA provider's first name.

Step 3. Click

when all data entry fields are completed.

Step 4. Click

and repeat steps 2, 3, and 4 to add another provider ID to the NCPDP Provider reference list.

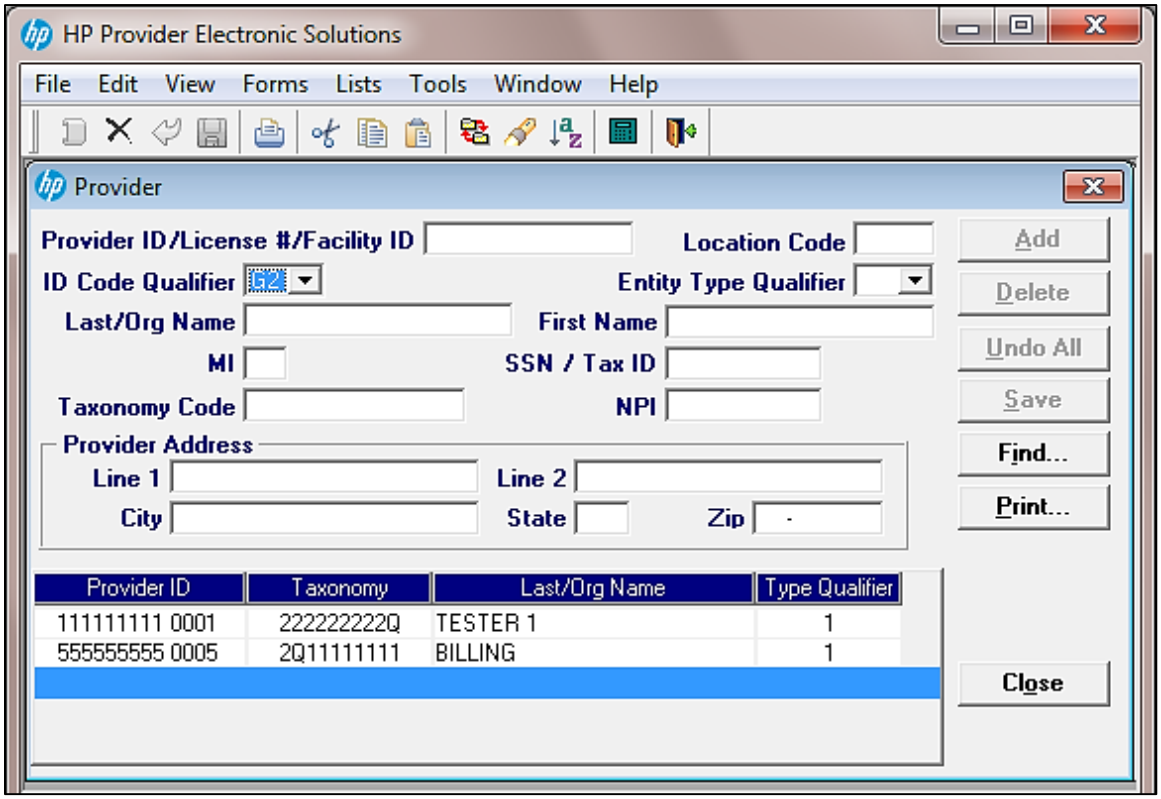
Step 5. Click

to exit the NCPDP Provider screen.

8.3 837 Provider Reference List

To complete the data-entry fields needed to add or edit an 837 Provider reference list selection, perform the following:

Step 1. Access the 837 Provider reference list.



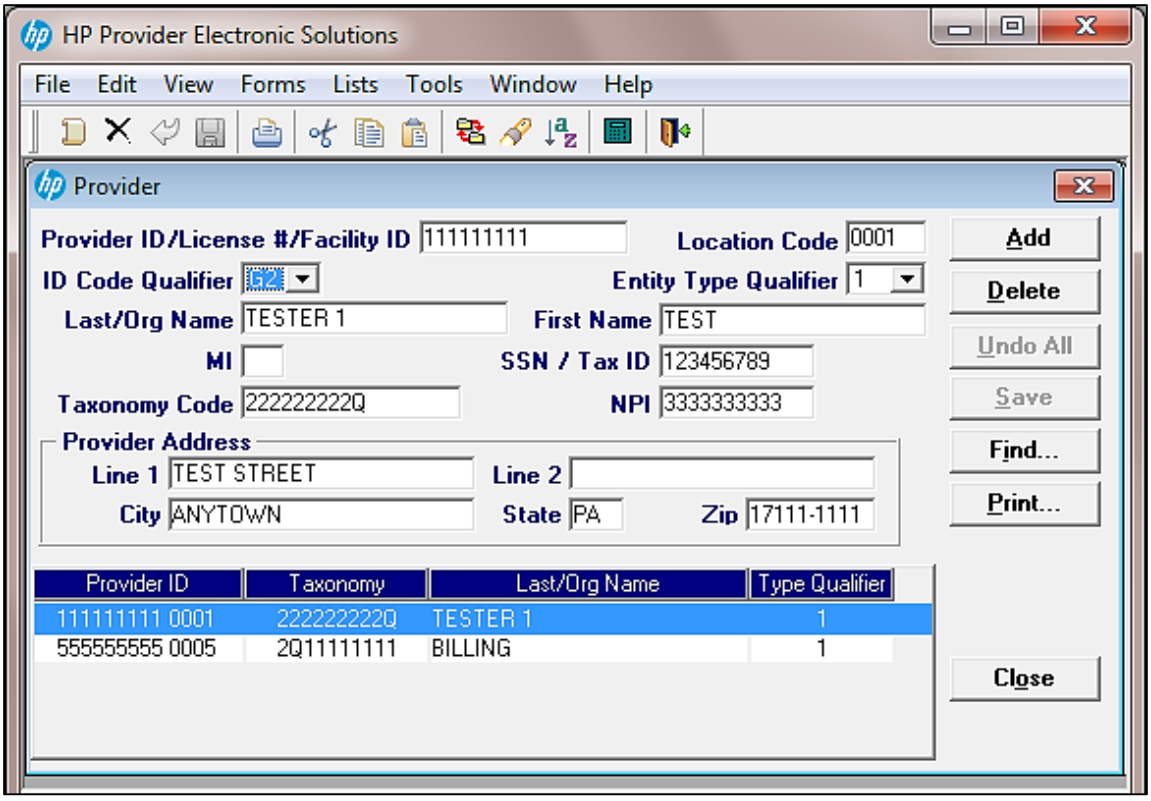
Step 2. Enter the data requested for each field, as described below.

Provider ID	Provider or group that receives payment for the services rendered, the individual provider that rendered services, or the facility where services were rendered. Enter the 9-digit Master Provider Index (MPI) number that was assigned to you by DHS. This reference list is also linked to the Referring and Rendering Provider ID fields, which means that when you access the dropdown selections for the Provider ID, Referring Provider ID or Rendering Provider ID, you access the same list of providers. This reference list is also linked to the Attending Provider, Referring Provider ID and Operating Physician fields used on the 837 Institutional Inpatient, Institutional Outpatient, and Institutional Nursing Facility; which means that when you access the dropdown selections for the Provider ID, Attending Provider, Referring Provider ID, or Operating Physician, you access the same list of providers. If one of your rendering providers is sometimes a referring provider, it is necessary to create a separate 7-digit entry for that provider. Referring Providers are generally identified by their 8 or 9 character state license number. The format for a license number is either 2-alpha,

	6-numeric OR 2-alpha, 6-numeric, 1-alpha. Service Facilities are identified by their 9-digit MPI. If using the Medical License Number in conjunction with the G2 qualifier '0B', enter the referring provider's 8- or 9-digit medical license number. The license number should be entered with two alpha characters, six numeric characters, and one alpha character, e.g., MD011234L. If the practitioner's license number was issued after June 29, 2001, enter the number in the new format, e.g., MD123456. **Note:** For Access Plus Referred Services, select the 13-digit MAID number for the referring provider from the field's pull down list.
Location Code	Enter the 4-digit location code that is applicable for the provider. If a provider has multiple location codes assigned, complete multiple entries with the same MPI, and each different location code assigned to the provider.
G2 Code Qualifier	Value submitted in the Provider G2 field. The format of this field consists of a preloaded dropdown box with two selections. The selections are as follows: **G2** – Medicaid Provider Number **0B** – Medical License Number If you select Medical License Number (0B) as the G2 Code Qualifier, no Service Location code is required.
Entity Type Qualifier	Identifies whether the information entered in this reference list selection represents a group/facility or individual. To complete this field, choose one of the two selections listed in the preloaded dropdown box. The selections are as follows: **1. Person** – Indicates that the information entered for this reference list selection relates to an individual provider. **2. Non-Person** – Indicates that the information being entered for this reference list selection relates to a group or facility
Last/Org Name	Enter the individual provider's last name or the business name of a group/facility in this field.
First Name	Enter the individual provider's first name. This field is only completed when the Entity Type Qualifier field has been populated with a selection of 1 (Person).
MI	Enter the individual provider's middle initial. This field is only completed when the Entity Type Qualifier field has been populated

	with a selection of 1 (Person). This field holds a maximum of 1 alpha character.
SSN/Tax ID	Enter the individual provider's 9-digit social security number or Tax ID number. Do not use hyphens, slashes, dashes, or spaces when completing this field. **Note:** If this value is not known, enter 999999999
Taxonomy Code	Required field. Lists the code designating the provider type, classification, and specialty. Enter the appropriate Taxonomy code. View the most recent list of approved Taxonomy codes at http://www.wpc-edi.com/codes/Codes.asp. If you have questions about which Taxonomy code you should use for your provider type, please contact Provider Inquiry or the Provider Assistance Center. **Note:** The Taxonomy code is crucial to using the NPI (National Provider Identifier). If entering an NPI as the primary identifier, you must use the correct Taxonomy code that you coordinated with Provider Enrollment for your legacy ID (Nine Digit Provider ID plus Four-Digit Service Location Code).
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Provider Address Line 1	Enter the individual provider's or facility's street address.
Provider Address Line 2	Enter additional address information, such as suite or apartment number, for the individual provider or facility being referenced.
City	Enter the City that corresponds with the street address.
State	Enter the two-letter abbreviation for the state that corresponds with the city listed in the City field.
Zip	Enter the required 9-digit zip code corresponding to the city and state listed in the City and State fields. This field holds a maximum of 9-numeric characters. **Note:** If the zip code is not 9 digits the file will fail. **Note:** If entering an NPI as the primary identifier, you must use the correct Nine-Digit Zip Code that you coordinated with Provider Enrollment for your legacy ID (Nine Digit Provider ID plus Four-Digit Service Location Code).

Step 3. Once all of the data entry fields is completed click Save. If any required fields were missed, you are prompted to complete them.



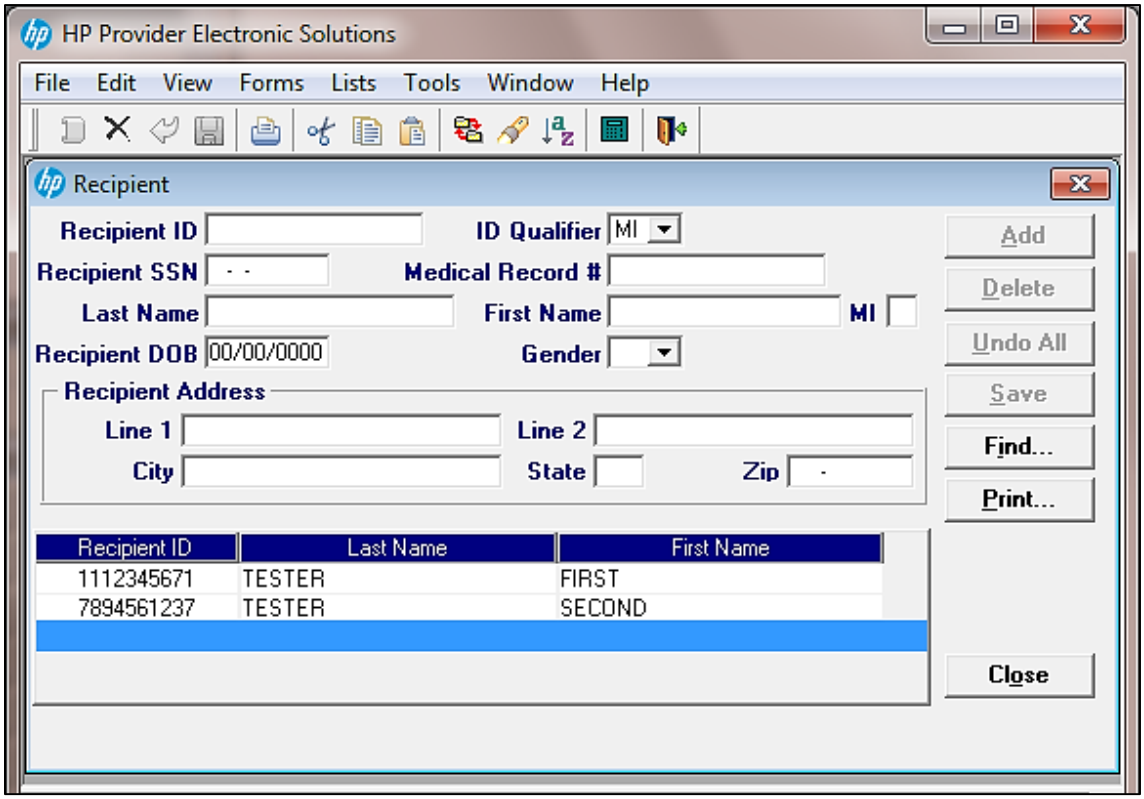
Step 4. To add another provider ID to the Provider reference list, click Add and repeat steps 2, 3, and 4, as shown above.

Step 5. Click Close to exit the Provider screen.

8.4 Recipient Reference List

To complete the data entry fields needed to add or edit a Recipient reference list, perform the following steps:

Step 1. Click **Lists/Recipient** to access the Recipient reference list.



Step 2. Enter the data requested for each field, as described below.

Recipient ID	Enter the recipient's 10-digit MA number, which is found on their Pennsylvania ACCESS card.
ID Qualifier	Choose the appropriate selection from the drop down box or enter an appropriate value as specified: **MI** – Member ID – Indicates the recipient's MA number was placed in the Recipient ID field.
Medical Record Number	Enter the recipient's medical record number, as assigned by the provider's office. This information does **not** appear on the claim or RA statement; however, it assists in reconciling claims and RA statements.
Recipient SSN	Enter the recipient's 9-digit social security number in the following format: 123456789. Do **not** use hyphens, slashes, dashes, or spaces when completing this field.
Last Name	Enter the recipient's last name.

First Name	Enter the recipient's first name.
MI	Enter the recipient's middle initial. This field accepts one alphanumeric character.
Recipient DOB	Enter the recipient's date of birth, using a 2-digit month, 2-digit day, and 4-digit year. 00/00/0000
Gender	Choose the appropriate gender selection from the drop down list or enter an appropriate value as specified: **F** – Female **M** – Male **U** – Unknown
Address Line 1	Enter the recipient's street address.
Address Line 2	Enter additional address information, such apartment number.
City	Enter the recipient's city.
State	Enter the abbreviation for the recipient's state. This field accepts a maximum of two characters (e.g., PA, MD).
Zip	Enter the recipient's ZIP code. This field accepts a maximum of 9 digits (ZIP Plus 4).

Step 3. Click

when all of the data entry fields are completed.

Step 4. Click

and repeat steps 2, 3, and 4 to add another recipient ID to the Recipient reference list.

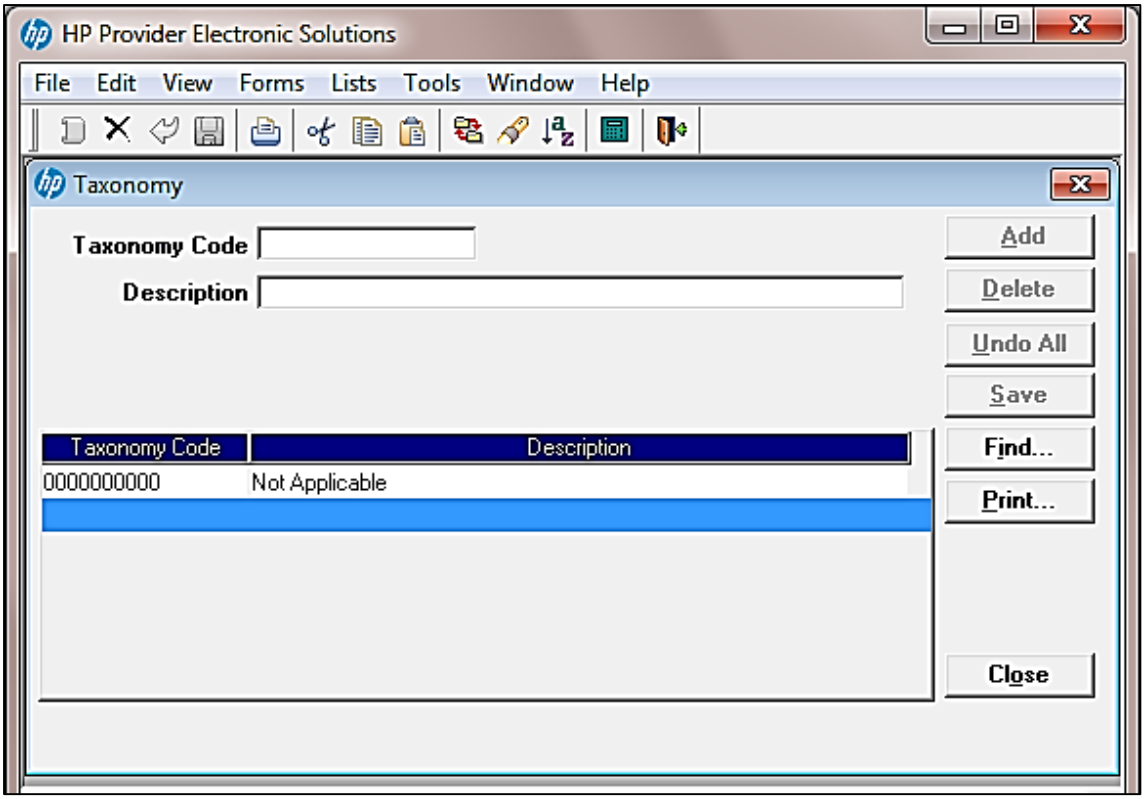
Step 5. Click

to exit the Recipient screen.

8.5 Taxonomy Reference List

To complete the data entry fields needed to add or edit a Taxonomy reference list selection, perform the following steps:

Step 1. Click **Lists/Taxonomy** to access the Taxonomy reference list.



Step 2. Enter the data requested for each field, as described below.

Taxonomy Code Enter the appropriate Taxonomy code. MA does not require this information to adjudicate a claim; however it is required to make your transaction HIPAA-compliant and to process the claim correctly.

A list of Taxonomy codes is found at:

www.wpc-edi.com/codes/codes.asp

Note: The Taxonomy code is crucial to using the NPI (National Provider Identifier). If entering an NPI as the primary identifier, you must use the correct Taxonomy code that you coordinated with Provider Enrollment for your legacy ID (Nine Digit Provider ID plus Four-Digit Service Location Code).

Description Enter the description of the taxonomy code.

Step 3. Click Save when all of the data entry fields are completed.

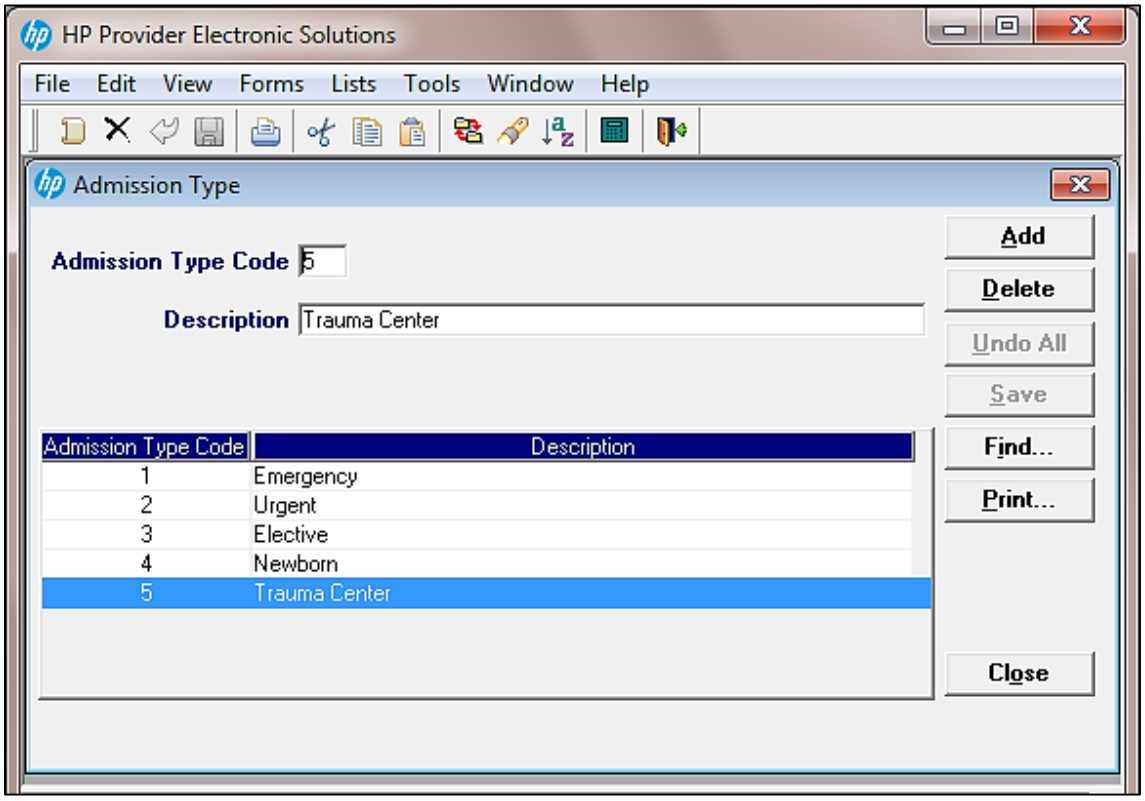
Step 4. Click Add and repeat steps 2, 3, and 4 to add another taxonomy code to the Taxonomy Code reference list,

Step 5. Click Close to exit the Taxonomy screen.

8.6 Admission Type Reference List Selection

To complete the data entry fields needed to add or edit an Admission Type reference list selection, perform the following steps:

Step 1. Click the **Lists/Admission Type** to access the Admission Type reference list.



Step 2. Enter the data requested for each field, as described below.

Admission Type Code	Enter the code that identifies the type of admission to the facility or choose the appropriate code from the field's preloaded drop down list as described below or enter an appropriate value as specified:	
	1 – Emergency Admission	Patient's condition requires immediate medical attention and any time delay would be harmful to the patient.
	2 – Urgent Admission	Patient's condition, while not immediately essential, should have medical attention provided very early to prevent possible loss or impairment of life, limb, or body function.
	3 – Elective Admission	Scheduled or planned admission.

	4 – Newborn Admission	Admission of a newborn baby
	5 – Trauma Center	Admission to a trauma center.
Description	Enter the description of the admission type code.	

Step 3. Click Save when all data entry fields are completed.

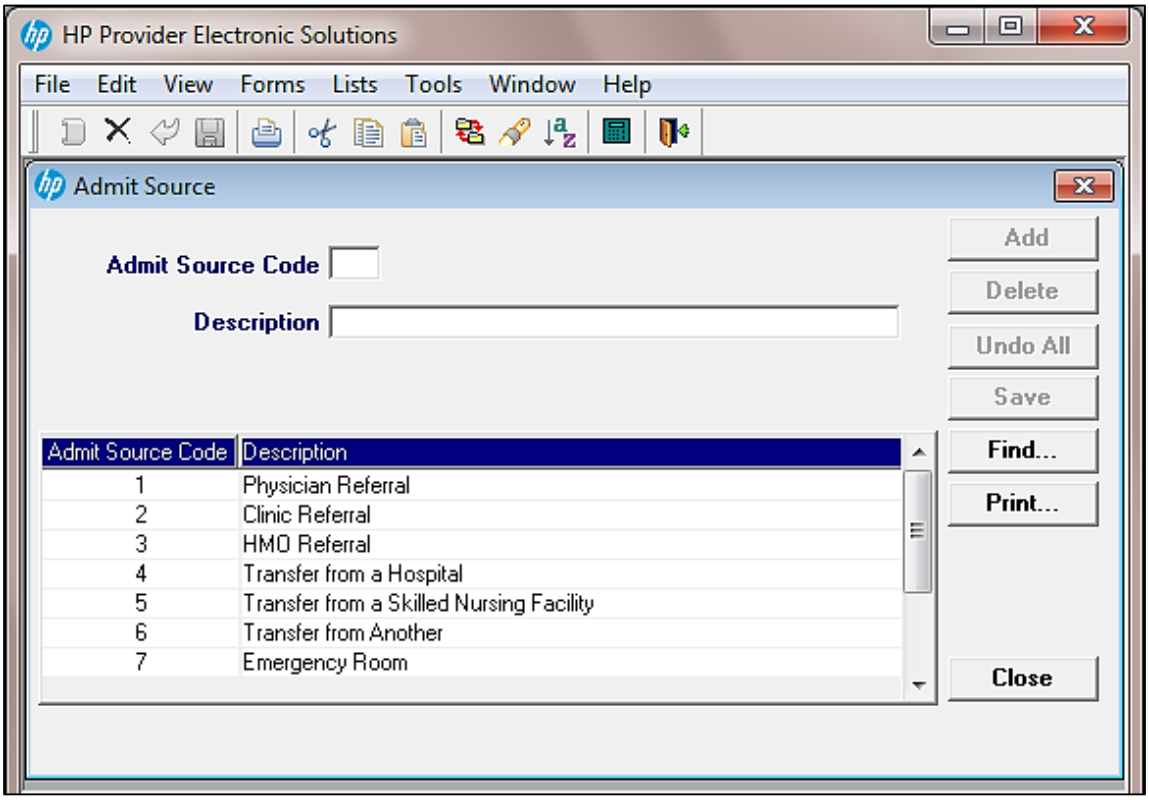
Step 4. Click Add and repeat steps 2, 3 and 4 to add another admission type code to the Admission Type reference list,

Step 5. Click Close to exit the Admission Type screen.

8.7 Admit Source Reference List Selection

To complete the data entry fields needed to add or edit an Admit Source reference list selection, perform the following steps:

Step 1. Click **Lists/Admit Source** to access the Admit Source reference list.



Step 2. Enter the data requested for each field, as described below.

Admit Source Code	Enter the code that identifies the source of admission to the facility or choose the appropriate code from the drop down list as described below or enter an appropriate value as specified:	
	1 – Physician Referral **2** – Clinic Referral **3** – HMO Referral **4** – Transfer from a Hospital **5** – Transfer from a Skilled Nursing Facility	**6** – Transfer from Another **7** – Emergency Room **8** – Court/Law **9** – Information Not Available **A** – Transfer from a Rural Primary Care Hospital
These values are preloaded and are HIPAA compliant. If any changes or modifications are required, you are notified by DHS or HP Enterprise Services.		
Description	Enter the description of the Admit Source code.	

Step 3. Click Save when all data entry fields are completed.

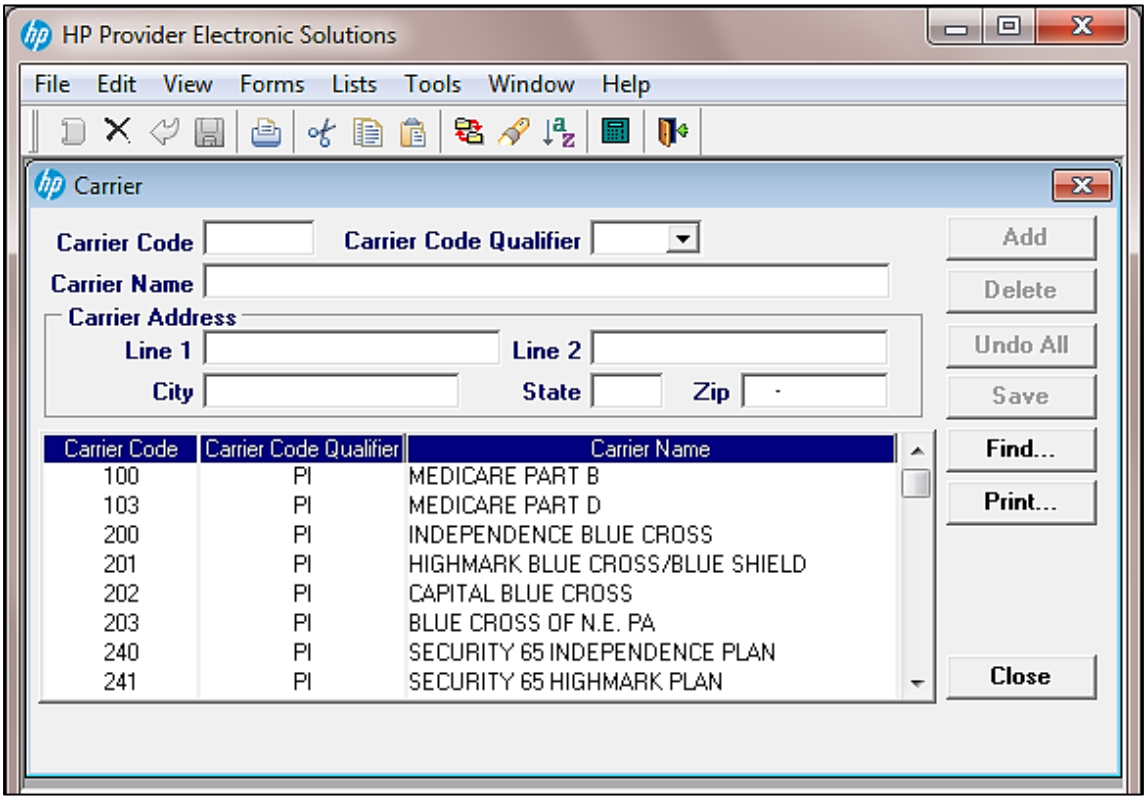
Step 4. Click Add and repeat steps 2, 3 and 4 to add another Admit Source Code to the Admit Source reference list.

Step 5. Click Close to exit the Admit Source screen.

8.8 Carrier Reference List

The Carrier Reference List has been updated for this version of PES. To complete the data entry fields needed to add or edit a Carrier reference list selection, complete the following steps:

Step 1. Click **Lists/Carrier** to access the Carrier reference list.



Step 2. Enter the data requested for each field, as described below.

Carrier Code	Enter the NEIC code that identifies the other insurance carrier, or choose the appropriate code from the drop down list or enter an appropriate value as specified. The carrier code is only requested on the Other Insurance (OI) screen.
Carrier Code Qualifier	Choose the code that identifies any qualifications that apply to the carrier code from the drop down box or enter an appropriate value as specified: **PI** – Payer Identification **XV** – HCFA Payer ID
Carrier Name	Enter the name of the other insurance carrier.

These values are preloaded and are HIPAA-compliant. If any changes or modifications need to be made to these values, you will be notified by DHS or HP Enterprise Services.

Step 3. Click

when all data entry fields are completed.

Step 4. Click

and repeat steps 2, 3 and 4 to add another carrier code to the Carrier reference list.

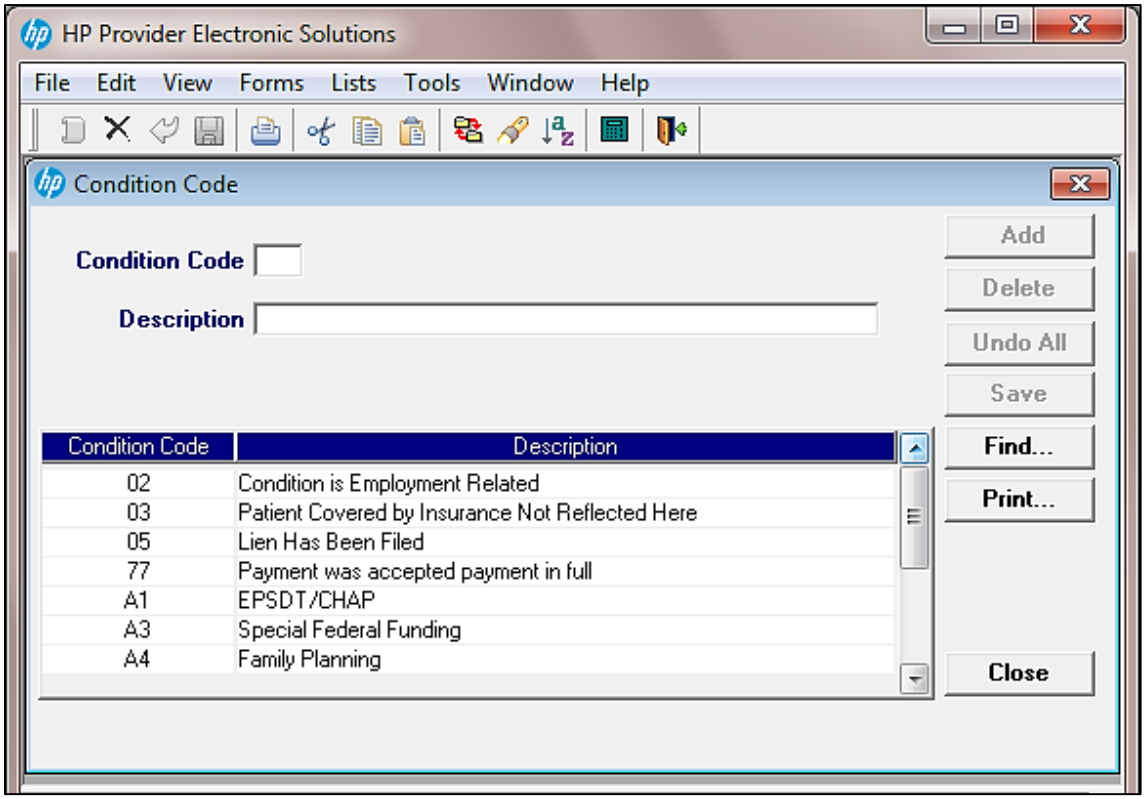
Step 5. Click

to exit the Carrier screen.

8.9 Condition Code Reference List

To complete the data entry fields needed to add or edit a Condition Code reference list selection, complete the following steps:

Step 1. Click **Lists/Condition Code** to access the Condition Code reference list.



Step 2. Enter the data requested for each field, as described below.

Condition Code	Choose the appropriate code from the drop down list that identifies conditions relating to a bill that may affect payer processing or enter an appropriate value as specified:	
	02 – Condition is Employment Related **03** – Patient Covered by Insurance Not Reflected Here **05** – Lien Has Been Filed **77** – Payment was accepted as payment in full **A1** – EPSDT/CHAP **A3** – Special Federal Funding	**A4** – Family Planning **A7 –** Induced Abortion – Danger to Life **A8 –** Inducted Abortion – Victim Rape/incest **AI** – Sterilization **B3** – Pregnancy Indicator **DR** – Disaster Related
Description	Enter the description of the condition code.	

These values are preloaded and are HIPAA compliant. If any changes or modifications need to be made to these values, you will be notified by DHS or HP Enterprise Services.

Step 3. Click Save when all data entry fields are completed.

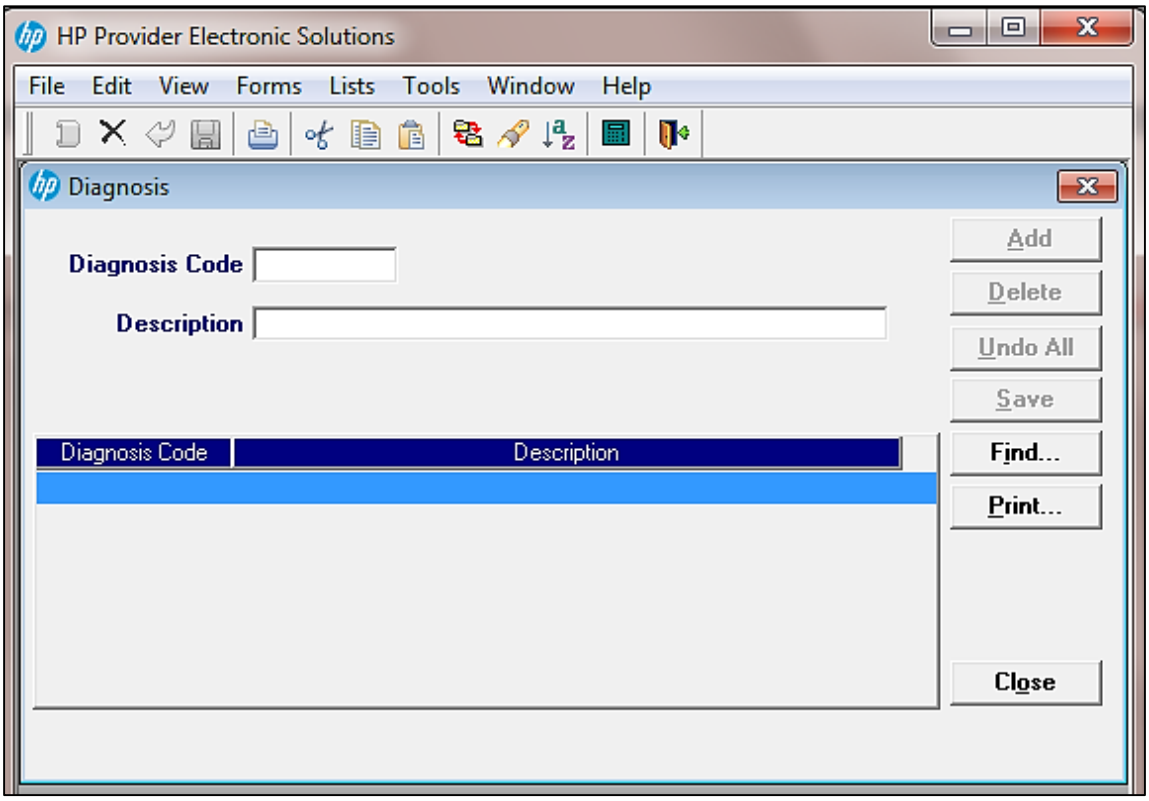
Step 4. Click Add and repeat steps 2, 3 and 4 to add another condition code to the condition code reference list.

Step 5. Click Close to exit the Condition Code screen.

8.10 Diagnosis Reference List/Diagnosis List

To complete the data entry fields needed to add or edit a Diagnosis reference list selection, perform the following steps:

Step 1. Click **Lists/Diagnosis** to access the Diagnosis reference list.



Step 2. Enter the data requested for each field, as described below.

Diagnosis Code	Enter the most specific diagnosis ICD-9-CM/ICD-10-CM/PCS code that relates to the recipient's visit.
Description	Enter a description of the diagnosis code.

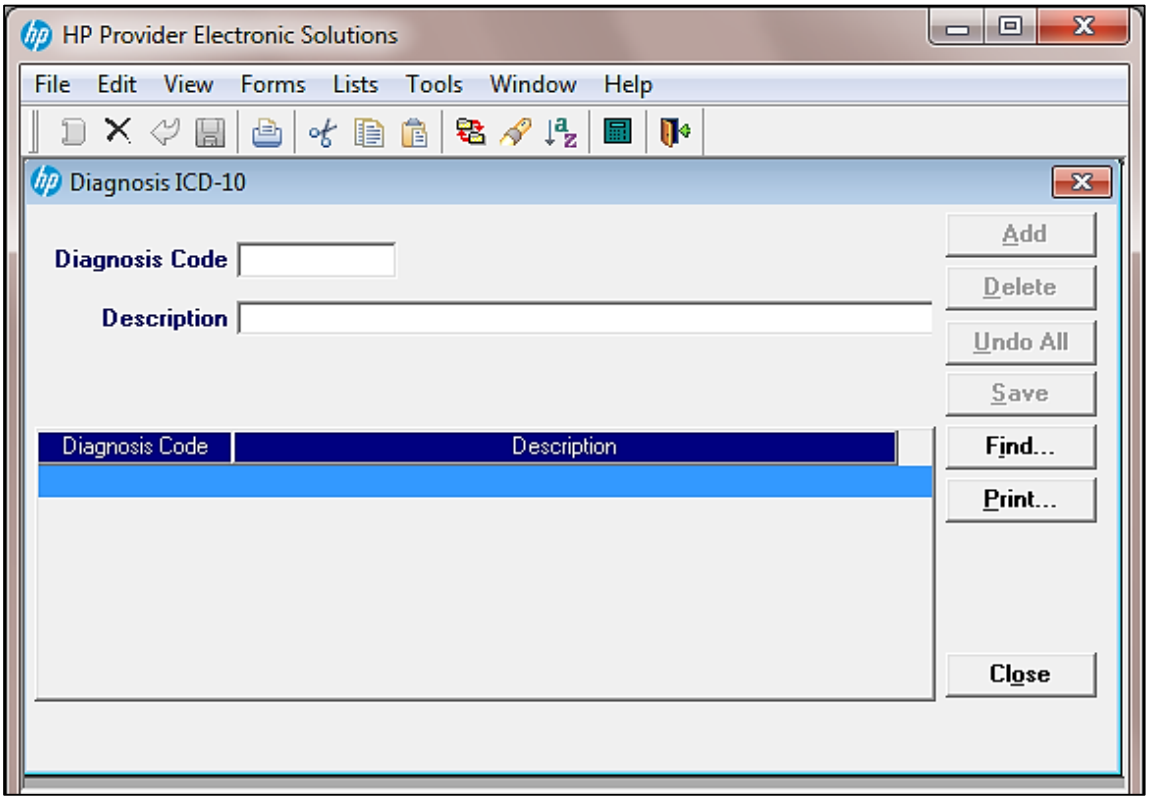
Step 3. Click Save when all data entry fields are completed.

Step 4. Click Add and repeat steps 2, 3 and 4 to add another diagnosis code to the diagnosis reference list.

Step 5. Click Close to exit the Diagnosis screen.

The following list will be used for the Diagnosis ICD-10 codes. Follow the instructions below.

Step. 1. Click **Lists/Diagnosis** ICD to access the Diagnosis reference list for Diagnosis ICD-10 reference list.



Step. 2. Enter the data requested for each field as described below.

Diagnosis Code	Enter the most specific diagnosis ICD-10-CM/PCS code that relates to the recipient's visit.
Description	Enter a description of the diagnosis code.

Step. 3. Click Save when all data entry fields are completed.

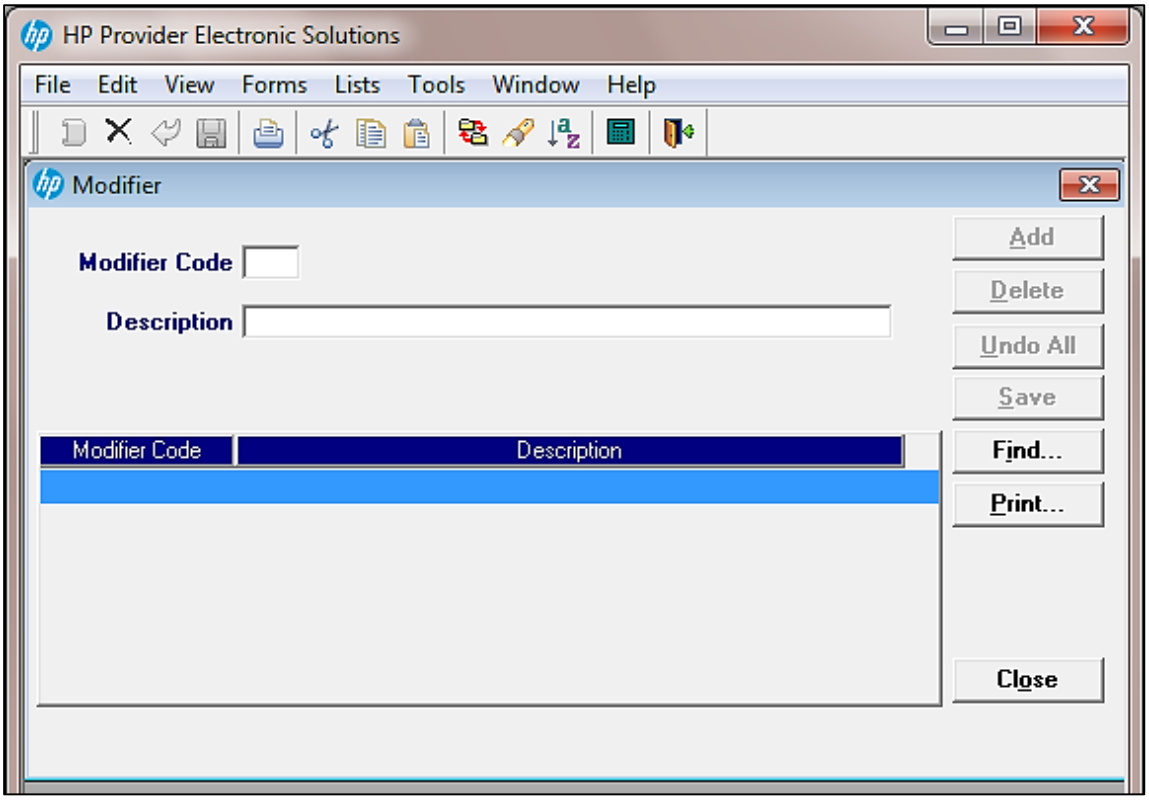
Step. 4. Click Add and repeat steps 2, 3 and 4 to add another diagnosis code to the diagnosis reference list.

Step. 5. Click Close to exit the Diagnosis ICD-10 screen.

8.11 Modifier Reference List

To complete the data entry fields needed to add or edit a modifier reference list selection, perform the following steps:

Step 1. Click **Lists/Modifier** to access the Modifier reference list.



Step 2. Enter the data requested for each field, as described below.

Modifier Code	Enter the 2-digit modifier for the procedure code that was entered in the Procedure field. Only enter a modifier if the procedure code requires a modifier, as indicated by the MA Program Fee Schedule.
Description	Enter a description of the modifier being added.

Step 3. Click Save when all data entry fields are completed,

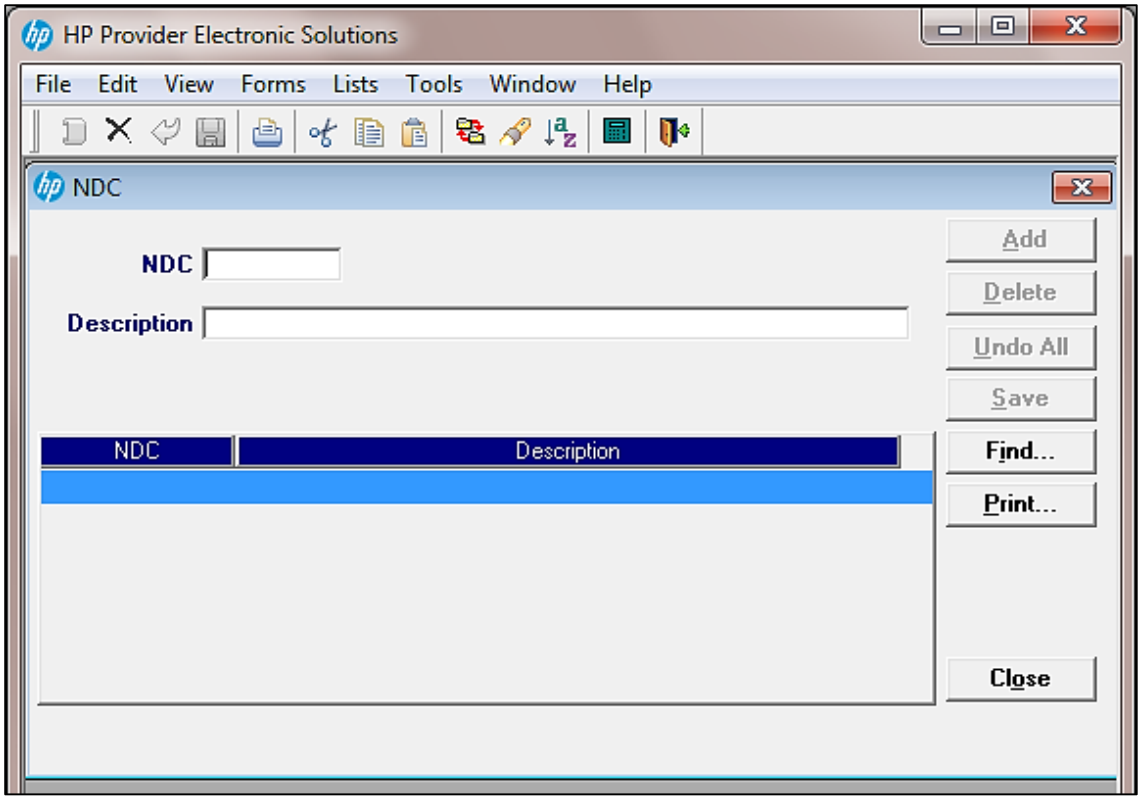
Step 4. Click Add and repeat steps 2, 3 and 4 to add another modifier code to the Modifier reference list,

Step 5. Click Close to exit the Modifier screen.

8.12 NDC Reference List

To complete the data entry fields needed to add or edit a National Drug Code (NDC) reference list selection, perform the following steps:

Step 1. Click **Lists/NDC** to access the NDC reference list.



Step 2. Enter the data requested for each field, as described below.

NDC	Enter the NDC for the drug dispensed. This field accepts a maximum of 11 numeric characters.
Description	Enter a description of the NDC being added.

Step 3. Click Save when all data entry fields are completed.

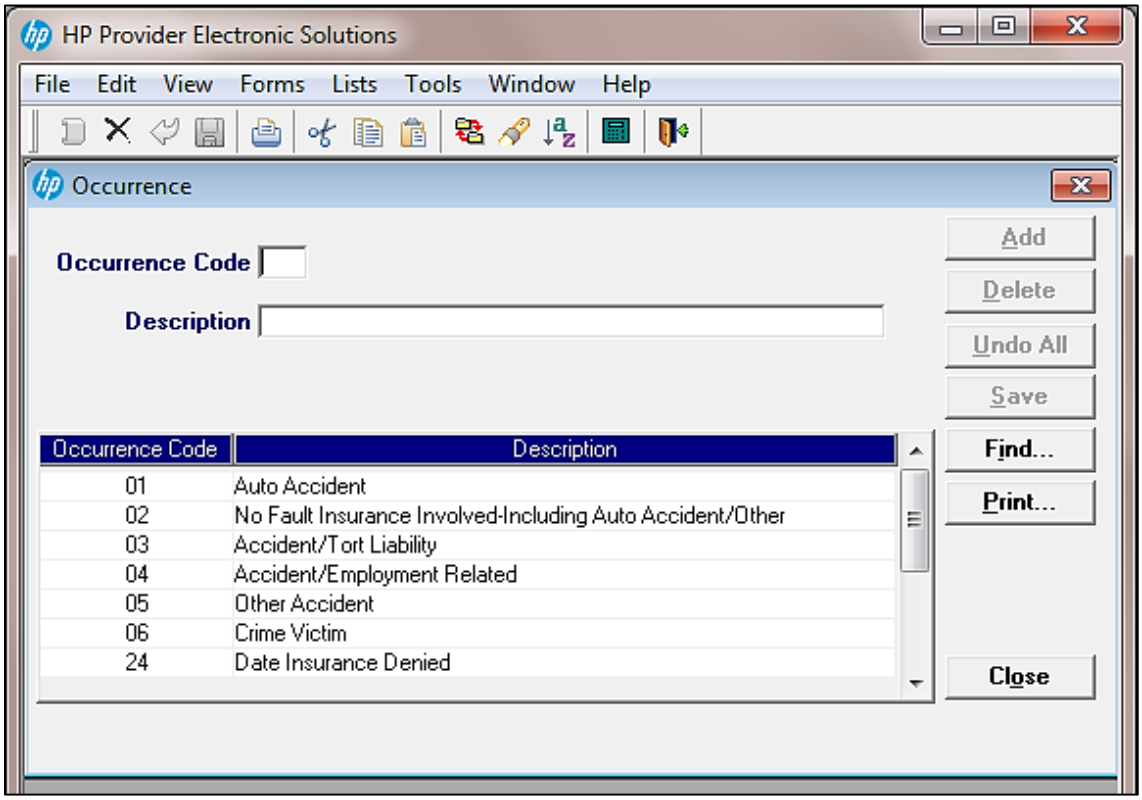
Step 4. Click Add and repeat steps 2, 3 and 4 to add another NDC to the NDC reference list.

Step 5. Click Close to exit the NDC screen.

8.13 Occurrence Reference List

To complete the data entry fields needed to add or edit an Occurrence reference list selection, perform the following steps:

Step 1. Click **Lists/Occurrence** to access the Occurrence reference list.



Step 2. Enter the data requested for each field.

Occurrence Code	Enter the code that defines significant events relating to the service, or enter an appropriate value as specified:	
	01 – Auto Accident **02** – No Fault Insurance Involved-Including Auto Accident/Other **03** – Accident/Tort Liability **04** – Accident/Employment Related **05** – Other Accident **06** – Crime Victim	**24** – Date Insurance Denied **25** – Date Benefits Terminated By Primary Payer **71** – Prior Stay Dates **74** – Noncovered Level of Care/Leave of Absence **DR** – Disaster Related **MR** – Disaster Related
Description	Enter a description of the occurrence.	

These occurrence code values are preloaded and are HIPAA-compliant. If any changes or modifications need to be made to these values, you will be notified by DHS or HP Enterprise Services.

Step 3. Click Save when all data entry fields are completed.

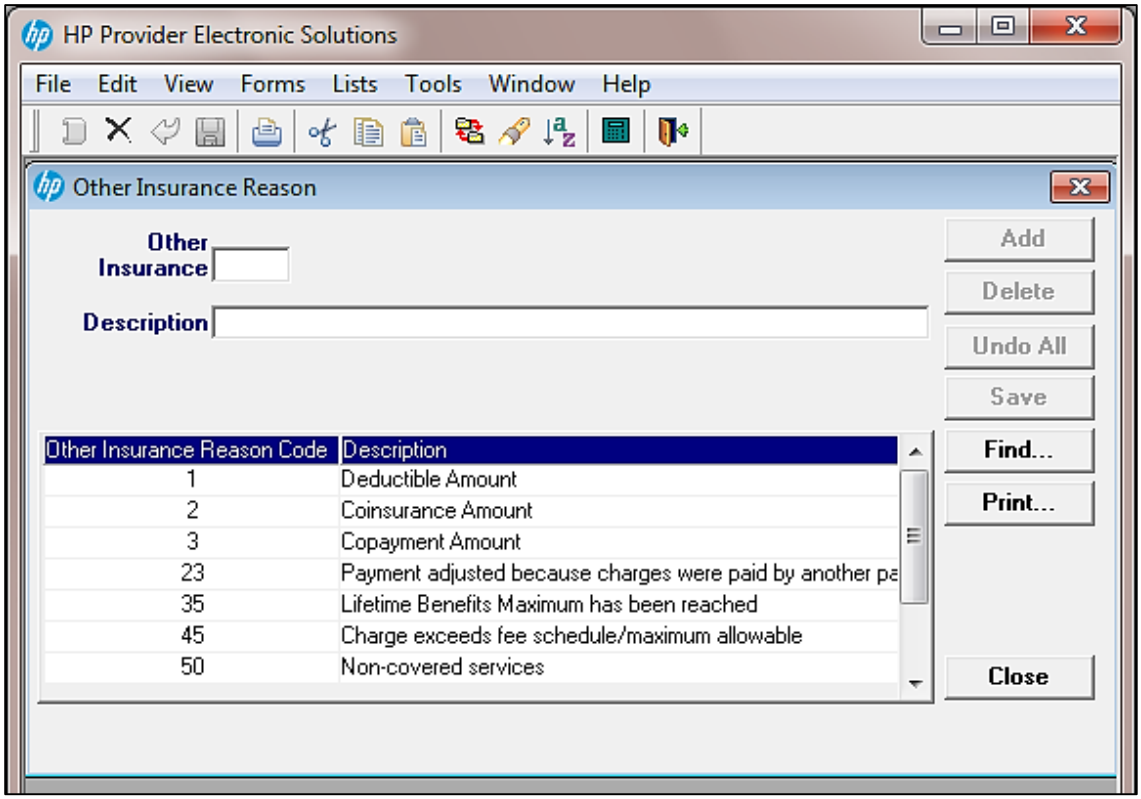
Step 4. Click Add and repeat steps 2, 3 and 4 to add another occurrence code to the Occurrence reference list.

Step 5. Click Close to exit the Occurrence screen.

8.14 Other Insurance Reason Reference List

To complete the data entry fields needed to add or edit Other Insurance Reason reference list selection, perform the following steps:

Step 1. Click **Lists/Other Insurance Reason** to access the Other Insurance Reason reference list.



Step 2. Enter the data requested for each field, as described below.

Other Insurance Reason Code	Enter the code that identifies the reason an adjustment was made by the other insurance carrier or enter an appropriate value as specified:	
	01 – Deductible Amount **02** – Coinsurance Amount **03** – Copayment Amount **23** – Payment adjusted because charges were paid by another payer **23** – Payment adjusted because charges were paid by another payer **35** – Lifetime Benefits Maximum has been reached	**45** - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement **50** – Non-covered services **118** – ESRD network support adjustment **119** – Benefit Maximum for this time period has been reached
Description	Enter a description of the other insurance reason being added.	

Step 3. Click

when all data fields are completed.

Step 4. Click

and repeat steps 2, 3 and 4 to add another other insurance reason code to the Other Insurance Reason reference list.

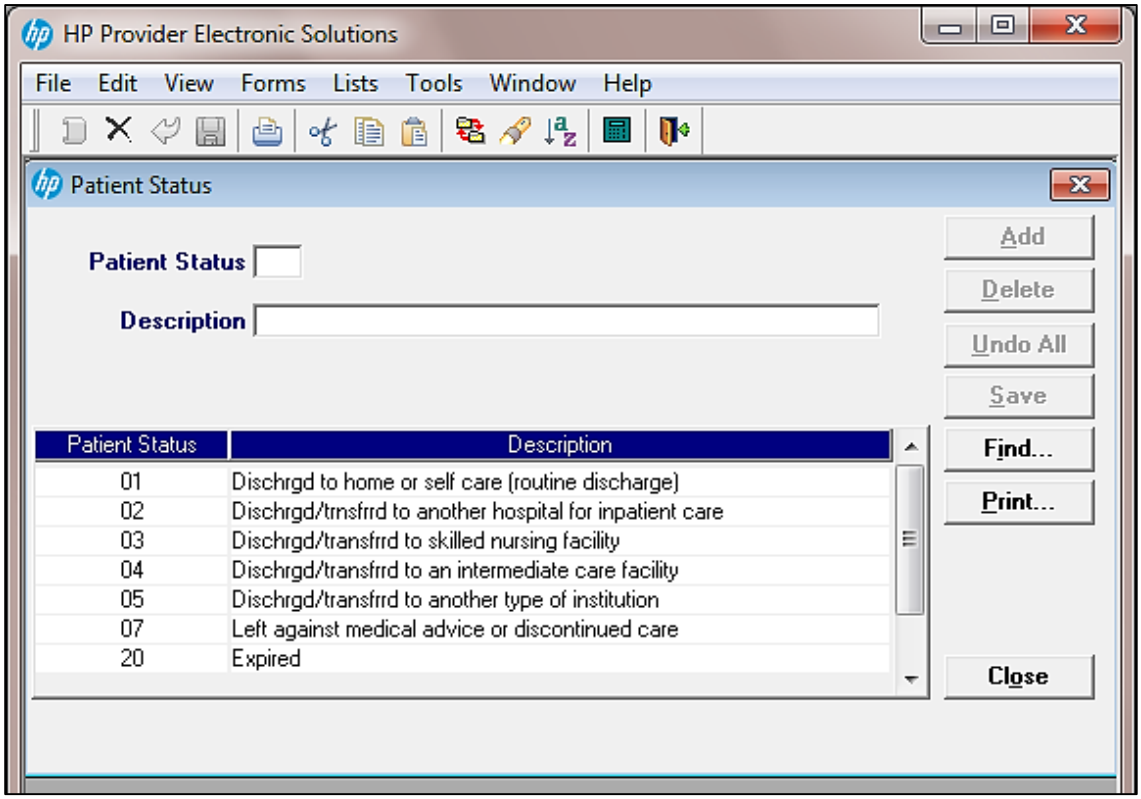
Step 5. Click

to exit the Other Insurance Reason screen.

8.15 Patient Status Reference List

To complete the data entry fields needed to add or edit a Patient Status reference list selection, perform the following steps:

Step 1. Click **Lists/Patient Status** to access the Patient Status reference list.



Step 2. Enter the data requested for each field, as described below.

Patient Status	Choose the code from the drop down box that identifies the patient's status, or enter an appropriate value as specified:	
	01 – Dischrgd to home or self-care (routine discharge) **02** – Dischrgd/trnsfrrd to another hospital for inpatient care **03** – Dischrgd/transfrrd to skilled nursing facility **04** – Dischrgd/transfrrd to an intermediate care facility	**05** – Dischrgd/transfrrd to another type of institution **07** – Left against medical advice or discontinued care **20** – Expired **30** – Still a patient
Description	Enter a description of the patient status code being added.	

These patient status values are preloaded and are HIPAA compliant. If any changes or modifications need to be made to these values, you will be notified by DHS or HP Enterprise Services.

Step 3. Click Save when all data entry fields are completed.

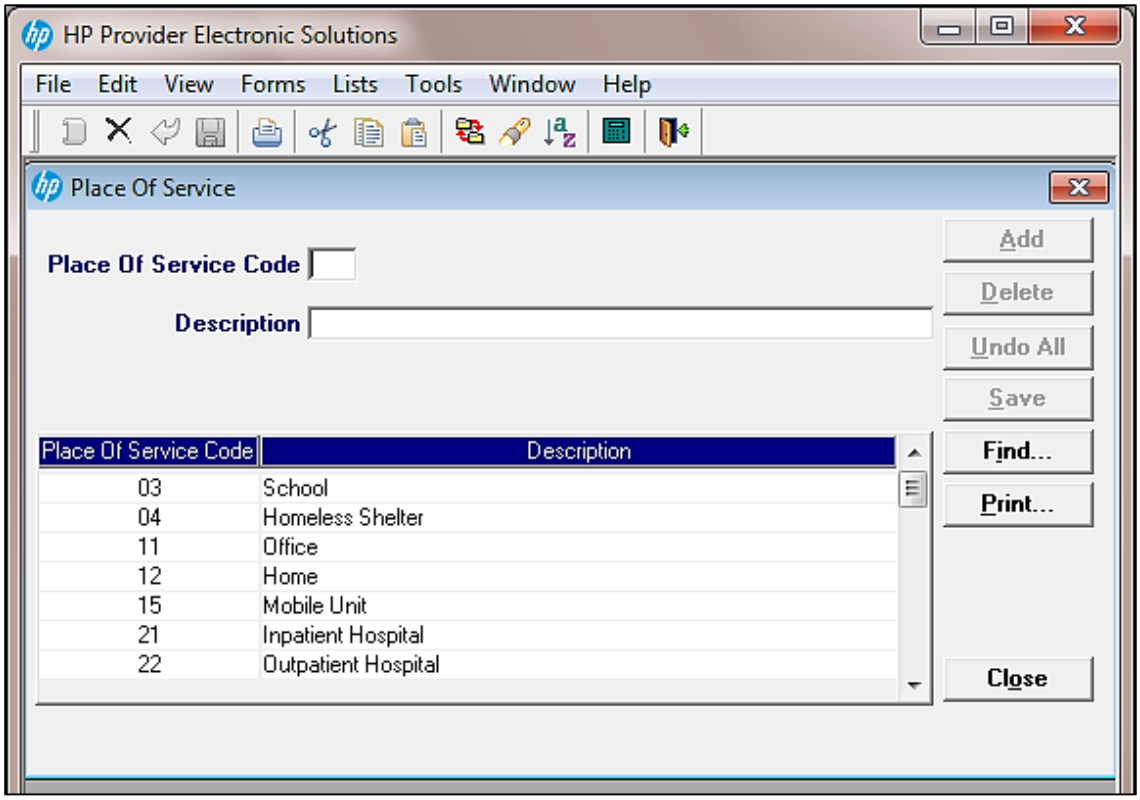
Step 4. Click Add and repeat steps 2, 3 and 4 to add another patient status code to the Patient Status reference list.

Step 5. Click Close to exit the Patient Status screen.

8.16 Place of Service Reference List

To complete the data entry fields needed to add or edit a Place of Service reference list selection, perform the following steps:

Step 1. Click **Lists/Place of Service** to access the Place of Service reference list.



Step 2. Enter the data requested for each field, as described below.

Place of Service Code	Enter the code for where the claim services were performed from the preloaded list, or enter an appropriate value as specified. These values are preloaded and are HIPAA compliant. If any changes or modifications need to be made to these values, you will be notified by DHS or HP Enterprise Services.	
	03 – School **04** - Homeless Shelter **11** – Office **12** – Home	**51** – Inpatient Psychiatric Facility **52** – Psychiatric Facility – Partial Hospitalization

	15 – Mobile Unit **21** – Inpatient Hospital **22** – Outpatient Hospital **23** – Emergency Room – Hospital **24** – Ambulatory Surgical Center **25** – Birthing Center **26** – Military Treatment Center **31** – Skilled Nursing Facility **32** – Nursing Facility **33** – Custodial Care Facility **34** – Hospice **35** – Adult Living Care Facility **41** – Ambulance – Land **42** – Ambulance – Air or Water **50** – Federally Qualified Health Center	**53** – Community Mental Health Care **54** – Intermediate Care Facility / Mentally Retarded **55** – Residential Substance Abuse Treatment Facility **56** – Psychiatric Residential Treatment Center **60** - Mass Immunization Center **61** – Comprehensive Inpatient Rehabilitation Facility **62** – Comprehensive Outpatient Rehabilitation Facility **65** – End Stage Renal Disease Treatment Facility **71** – State or Local Public Health Clinic **72** – Rural Health Clinic **81** – Independent Laboratory **99** – Other Unlisted Facility
Description	Enter a description of the place of service code being added.	

Step 3. Click

when all data entry fields are completed.

Step 4. Click

and repeat steps 2, 3 and 4 to add another place of service code to the Place of Service reference list.

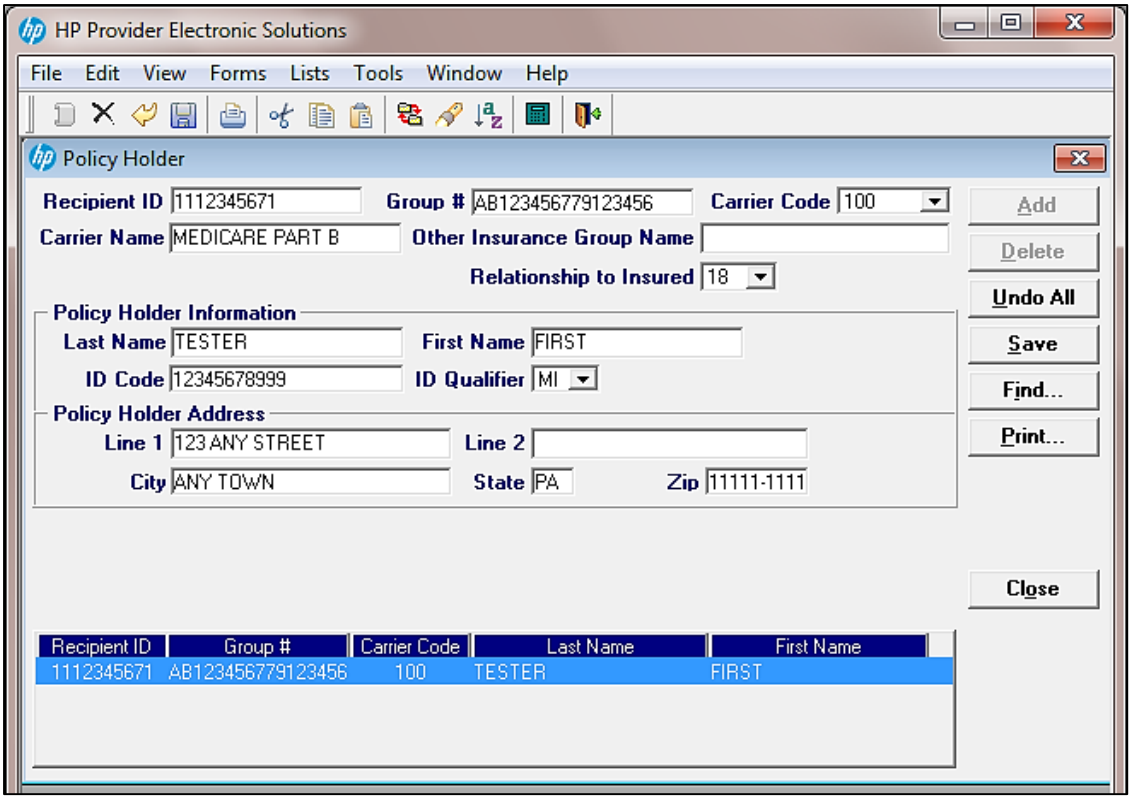
Step 5. Click

to exit the Place of Service screen.

8.17 Policy Holder Reference List

To complete the data entry fields needed to add or edit a Policy Holder reference list selection, perform the following steps:

Step 1. Click **Lists/Policy Holder** to access the Policy Holder reference list.



Step 2. Enter the data requested for each field, as described below.

Recipient ID	Select the appropriate recipient ID number from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. This code identifies the recipient.
Group #	Enter the group ID number assigned by the other insurance company.
Carrier Code	Select the appropriate carrier code from the drop down list, or enter an appropriate value as specified. The carrier code identifies the other insurance carrier.
Carrier Name	Populates automatically when the carrier code is selected. Contains the name of the other insurance carrier.
Other Insurance Group Name	Enter the group name of the other insurance.

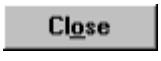
Relationship to Insured	Select the appropriate code from the drop down list or enter an appropriate value as specified. This field contains the relationship for the recipient's other insurance, and identifies the relationship between the recipient and the policyholder.
Last Name	Enter the policyholder's last name.
First Name	Enter the policyholder's first name.
ID Code	Enter the ID number assigned to the policyholder by the other insurance company.
ID Qualifier	Select the appropriate qualifier ID (MI –Member ID is the only option) from the drop down list or enter an appropriate value as specified. This code contains the qualifier code for the ID number assigned to the policyholder by the other insurance company. This field identifies any qualifications that apply to the policyholder.
Line 1-under Policy Holder Address	Enter the first line of the policyholder's street address
Line 2	Enter the second line of the policyholder's street address, if applicable.
City	Enter the city where the policyholder's street address is located.
State	Enter the 2-letter abbreviation used to identify the state where the policyholder's street address is located.
Zip	Enter the 5-digit ZIP code and 4-digit "+ 4 Code" for the policyholder's street address. The "+ 4 Code is not required to process a claim.

Step 3. Click

when all of the data entry fields are completed.

Step 4. Click

and repeat steps 2, 3, and 4 to add another policyholder to the Policy Holder reference list.

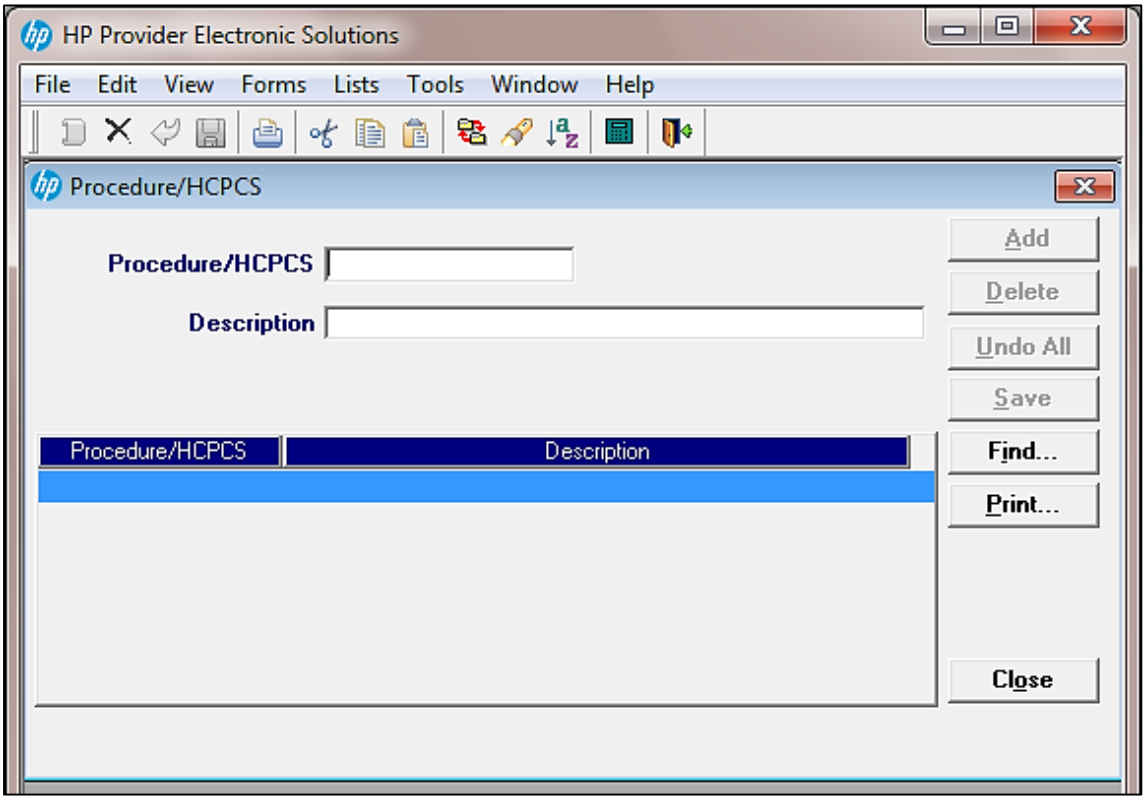
Step 5. Click 

to exit the Policy Holder screen.

8.18 Procedure/HCPCS Reference List

To complete the data entry fields needed to add or edit a Procedure/HCPCS reference list selection, perform the following steps:

Step 1. Click **Lists/Procedure/HCPCS** to access the Procedure/HCPCS reference list.



Step 2. Enter the data requested for each field, as described below.

Procedure/ HCPCS Code	Enter the HCPCS code that describes the service rendered, as indicated in the MA Program Fee Schedule.
Description	Enter a description of the procedure/HCPCS code.

Step 3. Click Save when all data entry fields are completed.

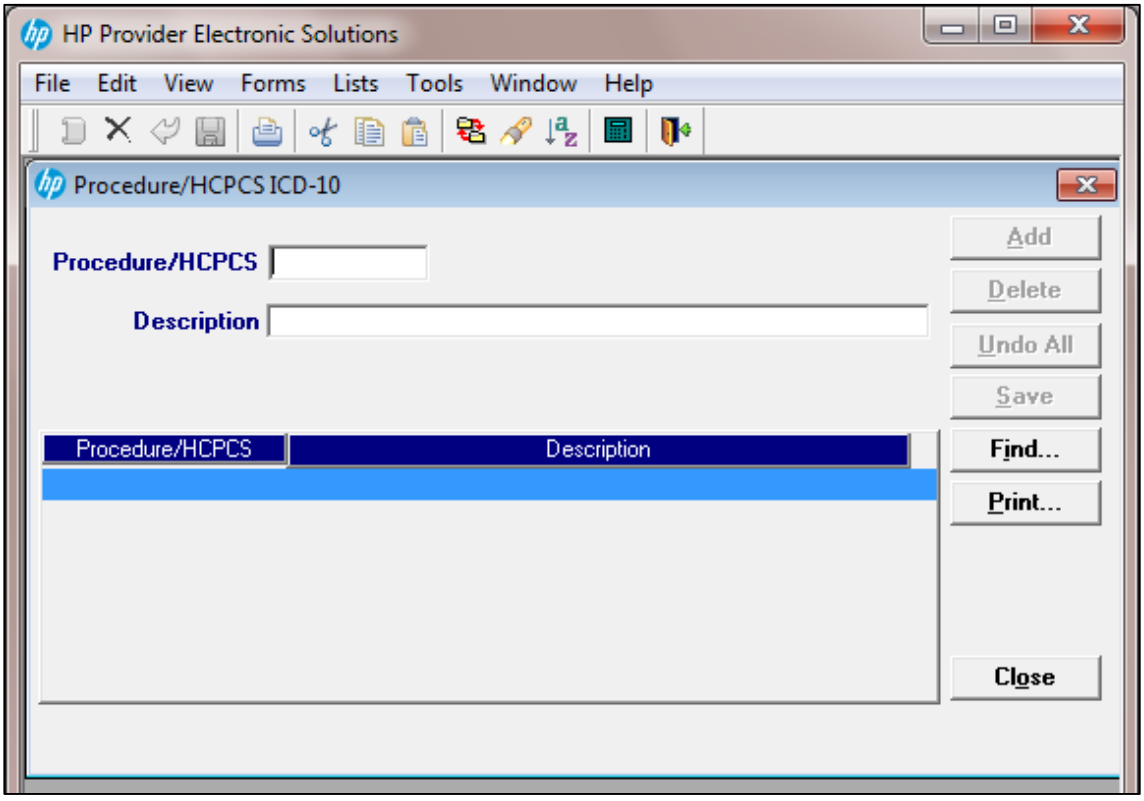
Step 4. Click Add and repeat steps 2, 3 and 4 to add another procedure/HCPCS code to the procedure/HCPCS reference list.

Step 5. Click Close to exit the Procedure/HCPCS screen.

Procedure/HCPCS ICD-10 Reference List

To complete the data entry fields needed to add or edit a Procedure/HCPCS ICD-10 reference list selection, perform the following steps:

Step. 1. Click **Lists/Procedure/HCPCS ICD-10** to access the Procedure/HCPCS ICD-10 reference list.



Step. 2. Enter the data requested for each field as described below.

Procedure/ HCPCS ICD-10 Code	Enter the HCPCS ICD-10 code that describes the service rendered, as indicated in the MA Program Fee Schedule.
Description	Enter a description of the procedure/HCPCS ICD-10 codes.

Step. 3. Click Save when all data entry fields are completed.

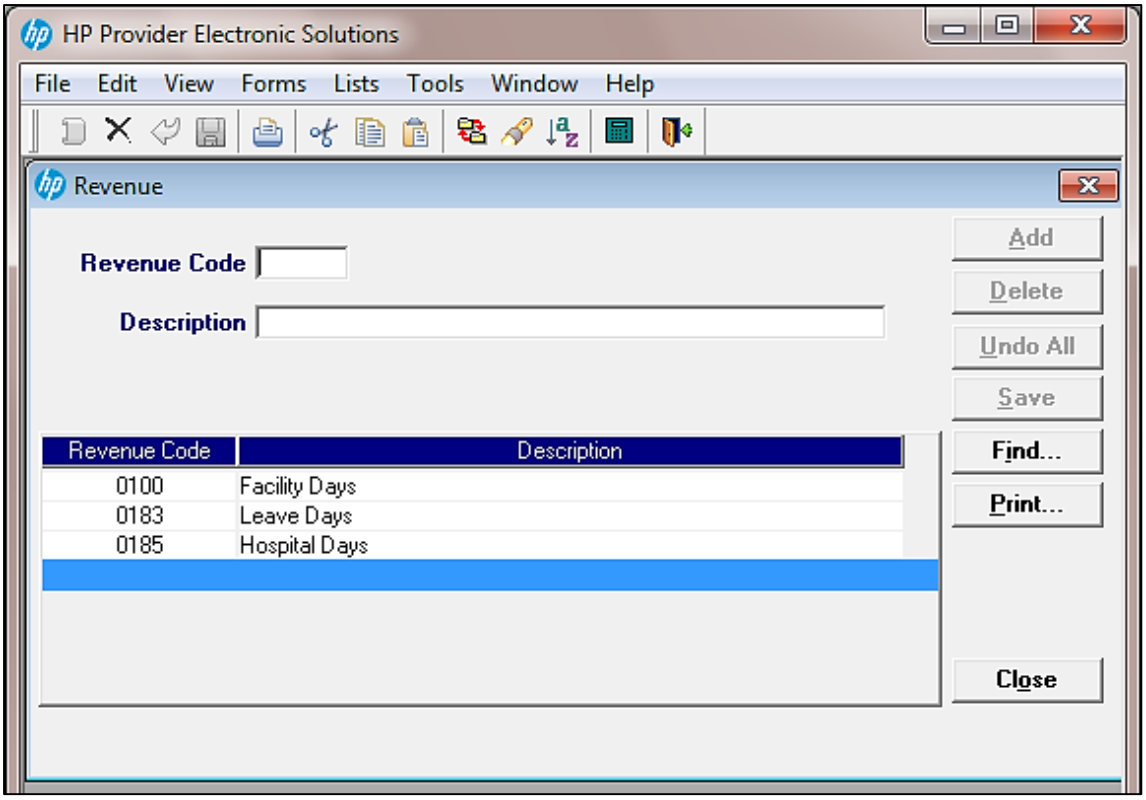
Step. 4. Click Add and repeat steps 2, 3 and 4 to add another Procedure/HCPCS ICD-10 code to the procedure/HCPCS ICD-10 reference list.

Step. 5. Click Close to exit the Procedure/HCPCS ICD-10 screen.

8.19 Revenue Reference List

To complete the data entry fields needed to add or edit a Revenue reference list selection, complete the following steps:

Step 1. Click **Lists/Revenue** to access the Revenue reference list.



Step 2. Enter the data requested for each field, as described below.

Revenue Code	Enter the code that identifies a specific accommodation or ancillary service.

	The software is pre-populated with revenue codes used for Long Term Care billing. Additional revenue codes for other billing types can be added as needed.
Description	Enter a description of the revenue code.

Step 3. Click Save when all of the data entry fields are completed.

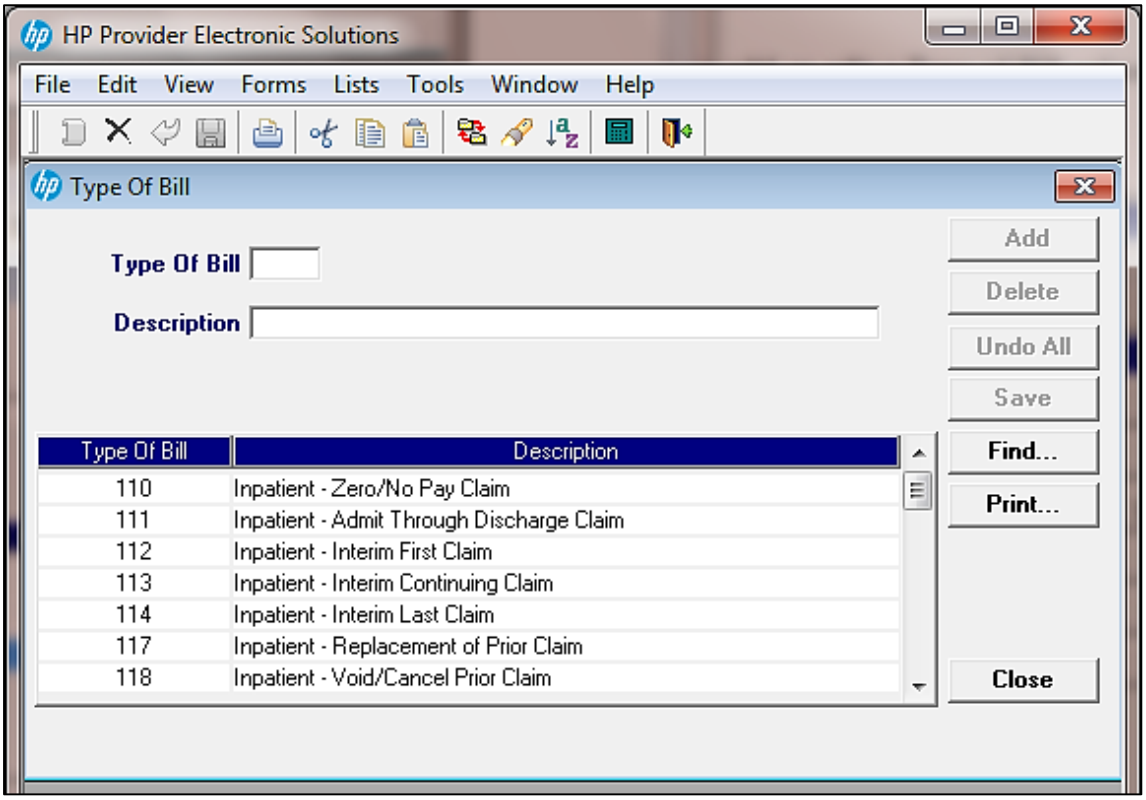
Step 4. Click Add and repeat steps 2, 3, and 4 to add another revenue code to the revenue reference list,

Step 5. Click Close to exit the Revenue screen.

8.20 Type of Bill Reference List

To complete the data entry fields needed to add or edit a Type of Bill reference list selection, perform the following steps:

Step 1. Click **Lists/Type of Bill** to access the Type of Bill reference list.



Step 2. Enter the data requested for each field, as described below.

Type of Bill Code	Enter the code that identifies the type of bill or choose the appropriate code from the drop down list as described below or enter an appropriate value as specified.
Form Name	**Type of Bill Codes**
837 Institutional Inpatient	**110** – Zero Payment (Zero Claim) **111** – Admit Through Discharge Claim **112** – Interim – First Claim **117** – Replacement of Prior Claim **118** – Void/Cancel of Prior Claim **Note:** Types of Bills 113 and 114 and not valid values for PA MA
837 Institutional Nursing Facility(County and General Nursing Facilities, State Mental Hospitals)	County Nursing Facilities, General Nursing Facilities, State Mental Facilities use a type of bill code that starts with 26. **260** Nursing Home – Zero/No Pay Claim **261** Nursing Home – Admit Through Discharge Claim **262** Nursing Home – Interim First Claim **263** Nursing Home – Interim Continuing Claim **264** Nursing Home – Interim Last Claim **267** Nursing Home – Replacement of Prior Claim **268** Nursing Home – Void/Cancel of Prior Claim
837 Institutional Outpatient (Outpatient Hospital)	**131** Outpatient Hospital – Original Claim **137** Outpatient Hospital – replacement of Prior Claim **138** Outpatient Hospital – Void/Cancel of Prior Claim
837 Institutional Outpatient (Hospital Special Treatment Room**)**	**141** Hospital Referenced Diagnostics – Original Claim **147** Hospital Referenced Diagnostics – Replacement of Prior Claim **148** Hospital Referenced Diagnostics – Void/Cancel of Prior Claim
837 Institutional Outpatient (Ambulatory Surgical Center)	**830** Ambulatory Surgical Center – Zero/No Pay Claim **831** Ambulatory Surgical Center –Original Claim **837** Ambulatory Surgical Center – Replacement of Prior Claim **838** Ambulatory Surgical Center – Void/Cancel of Prior Claim

Intermediate Care Facilities (State Mental Retardation Centers, ICF/MR Facilities, ICF/ORC Facilities)	**650 ICF/MR** – Zero/No Pay Claim **651 ICF/MR** – Admit Through Discharge Claim **652 ICF/MR** – Interim First Claim **653 ICF/MR** – Interim Continuing Claim **654 ICF/MR** – Interim Last Claim **657 ICF/MR** – Replacement of Prior Claim **658 ICF/MR** – Void/Cancel of Prior Claim **Note:** The last digit should be selected based on the definitions below: **0 – Non Payment/Zero Claim** – This code should be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill. **1 – Admit Through Discharge Claim** – This code should be used for a bill that is expected to be the only bill received for a course of treatment or confinement. **2 – Interim/First Claim** – This code is to be used for the first of a series of bills to the same payer for the same confinement. **3 – Interim/Continuing Claim** – This code is to be used for when a bill for the same confinement or course of treatment will be submitted. **4 – Interim/Last Claim** – This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that no further bills for the same confinement or course of treatment will be submitted. **7 – Replacement of a Prior Claim** – This code is to be used when a bill has been submitted and paid and needs to be adjusted. **8 – Void/Cancel of Prior Claim** – This code reflects the elimination of a previously submitted bill.
Description	Enter a description of the type of bill code.

Step 3. Click

when of the data entry fields are completed.

Step 4. Click

and repeat steps 2, 3, and 4 to add another type of bill code to the Type of Bill reference list.

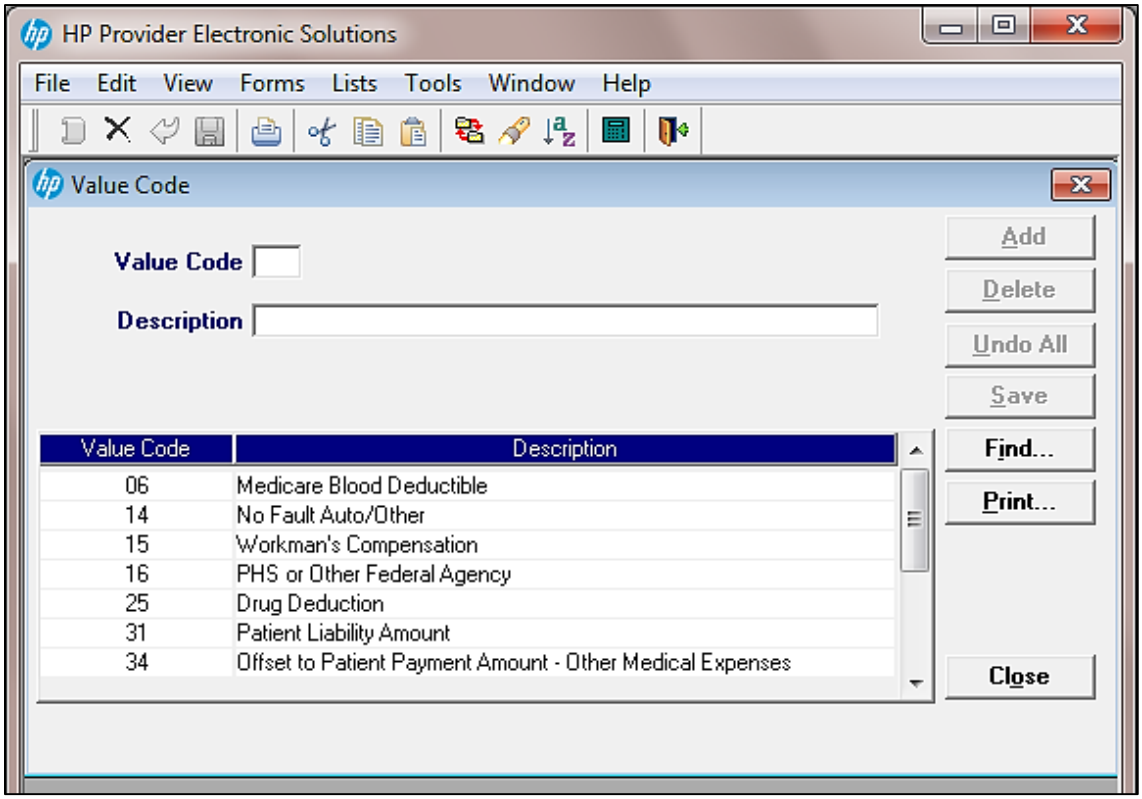
Step 5. Click

to exit the Type of Bill screen.

8.21 Value Code Reference List

To complete the data entry fields needed to add or edit a Value Code reference list selection, perform the following steps:

Step 1. Click **Lists/Value Code** to access the Value Code reference list.



Step 2. Enter the data requested for each field.

Value Code	Enter the National Uniform Billing Committee (NUBC) code that relates amounts or values to identify data elements necessary to process a form as qualified by the payer organization. These values are preloaded and are HIPAA-compliant. If any changes or modifications need to be made to these values, you will be notified by DHS or HP Enterprise Services. Select the appropriate value from the drop down list or enter an appropriate value as specified.	
	06 – Medicare Blood Deductible **14** – No Fault Auto/Other **15** – Workman's Compensation **16** – PHS or Other Federal Agency **25** – Drug Deduction **31** –Patient Liability Amount **34** – Offset to Patient Payment Amount – Other Medical Expenses	**35** – Offset to Patient Payment Amount – Health Insurance Premiums **38** – Medicare Blood Deductible Pints Furnished **39** – Medicare Blood Deductible Pints Replaced **47** – Any Liability Insurance **66** – Patient Paid Amount
Description	Enter a description of the value code.	

Step 3. Click

when the data entry fields are completed.

Step 4. Click

and repeat steps 2, 3 and 4 to add another type of value code to the Value Code reference list.

Step 5. Click

to exit the Value Code screen.

9 Form Overview

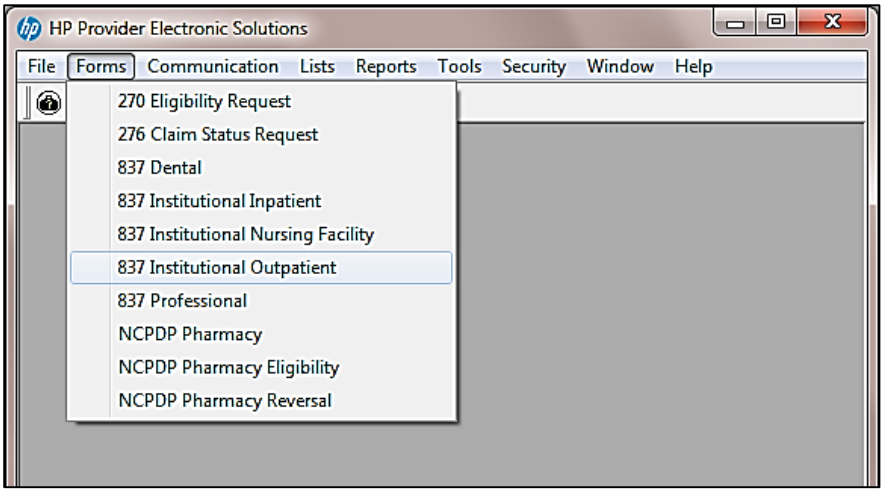
The Provider Electronic Solutions software provides several HIPAA-ready forms. These forms are used to complete and edit Pennsylvania MA claims and eligibility requests. Instead of completing a claim on paper, you can complete a claim on your computer using the Provider Electronic Solutions software.

After you complete a form, save it to process other claims. The Provider Electronic Solutions software lets you submit a group or batch of forms at one time, as well as submitting certain forms individually.

The Provider Electronic Solutions software features the following form types:

- 270/271 Eligibility Inquiry and Response
- 276/277 Claim Status Request and Response
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Facility
- 837 Institutional Outpatient
- 837 Professional
- NCPDP Pharmacy
- NCPDP Eligibility
- NCPDP Pharmacy Reversal

You can access these forms from the **Forms** drop down menu, located on the Provider Electronic Solutions software main menu, as shown below, or via the Toolbar shortcut icons:



9.1 Complete a 270 Eligibility Request

Use the 270 Eligibility form to verify recipient eligibility. This form is divided into three screens. Each screen contains:

Screen	Description
Header 1	Provider and recipient information.
Header 2	Information about a specific request.
Service	Service Type code

Use one of the following combinations of recipient information to recipient eligibility:

- Recipient ID number and card issue number.
- Recipient Social Security Number (SSN) and birth date.
- Recipient first and last name and birth date.

Please use the most specific information available to obtain the most accurate eligibility information possible.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

To create a 270 Eligibility Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, access the 270 Eligibility Request Form using one of the two ways listed below:

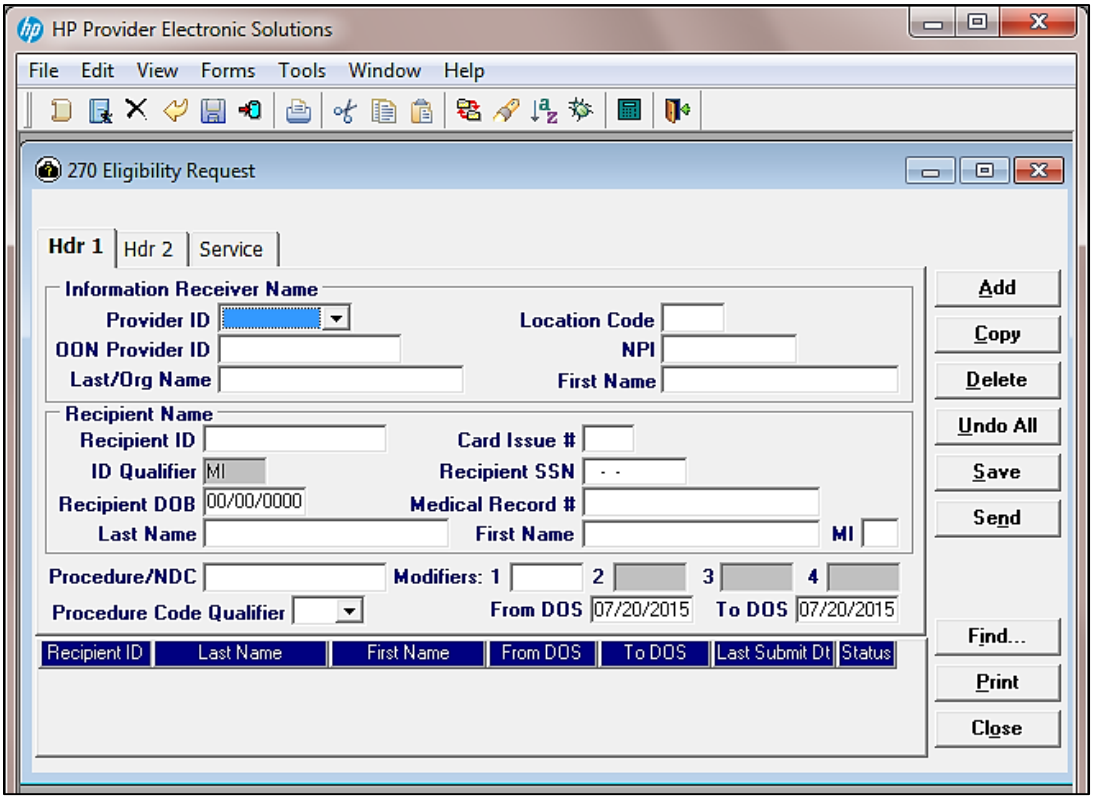
Click (270 Eligibility Request Shortcut Button) on the Toolbar

or

Select the 270 Eligibility Request Option from the Forms drop down menu:

The 270 Eligibility Request form is displayed, with the Header 1 screen displayed, as shown on the next screen.

Step 2. Complete Header 1.



Header One	Contains the provider and recipient information required to submit a 270 Eligibility Request. To complete the Header One screen, perform the following steps: Choosing a selection from a drop down list automatically populates several fields.
Provider ID	Select the 9-digit provider number from the drop down list or enter an appropriate value as specified. (required field)
Location Code	Field is automatically populated with the appropriate data after you select a provider number from the Provider ID field. (required field)
OON Provider ID	Out Of Network Provider ID number-enter the appropriate value. MA provides the OON provider ID for providers that operate outside of Pennsylvania's MA network.
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.

Last/Org Name	Provider's last name. This field is automatically populated after you select a provider number from the Provider ID field.
First Name	Provider's first name. This field is automatically populated after you select a provider number from the Provider ID field
Recipient ID	Select the 10-digit recipient number from the drop down list or enter an appropriate value as specified. This field is found on the recipient's Pennsylvania ACCESS card.
Card Issue Number	Enter the recipient's 2-digit card issue number, which is located on the recipient's Pennsylvania ACCESS card. (Required if using recipient ID for eligibility)
ID Qualifier	This field contains the qualifier code for the ID Number assigned to the policy holder by the carrier. The default is "MI" for Medicaid recipients' ID.
Recipient SSN	Contains the recipient's 9-digit social security number. This field is automatically populated when you select a recipient number from the Recipient ID field.
Recipient DOB	Recipient's date of birth. This field is automatically populated when you select a Recipient Number from the Recipient ID field. (Field is required if using recipient's SSN or name for eligibility.)
Medical Record Account #	Your own identification number for the recipient. This field is automatically populated when you select a recipient number from the recipient ID field.
Last Name	Recipient's last name. This field is automatically populated when you select a recipient number from the recipient ID field.
First Name	Recipient's first name. This field is automatically populated when you select a recipient number from the Recipient ID field. (Field is required if using recipient last name for eligibility.)
MI	Recipient's middle initial. This field is automatically populated when you select a recipient number from the Recipient ID field. (Recommended if using recipient last name for eligibility)
Procedure/NDC	Enter the procedure code or NDC code for which you are requesting eligibility.

Modifiers	1-4 Enter the 2-digit modifier for the procedure code entered in the Procedure field if the MA Program Fee Schedule indicates that the procedure code requires a modifier.
Procedure Code Qualifier	Enter the qualifier for the code set that matches the code you entered into the procedure/NDC code.
From DOS (From Date Of Service)	Enter the first date of a range of dates to check recipient eligibility. If you only check for a single date, enter the same date in both the From DOS and the To DOS fields.
To DOS (To Date Of Service)	Enter the last date of a range of dates to check recipient eligibility. If you only check for a single date, enter the same date in both the From DOS and the To DOS fields.

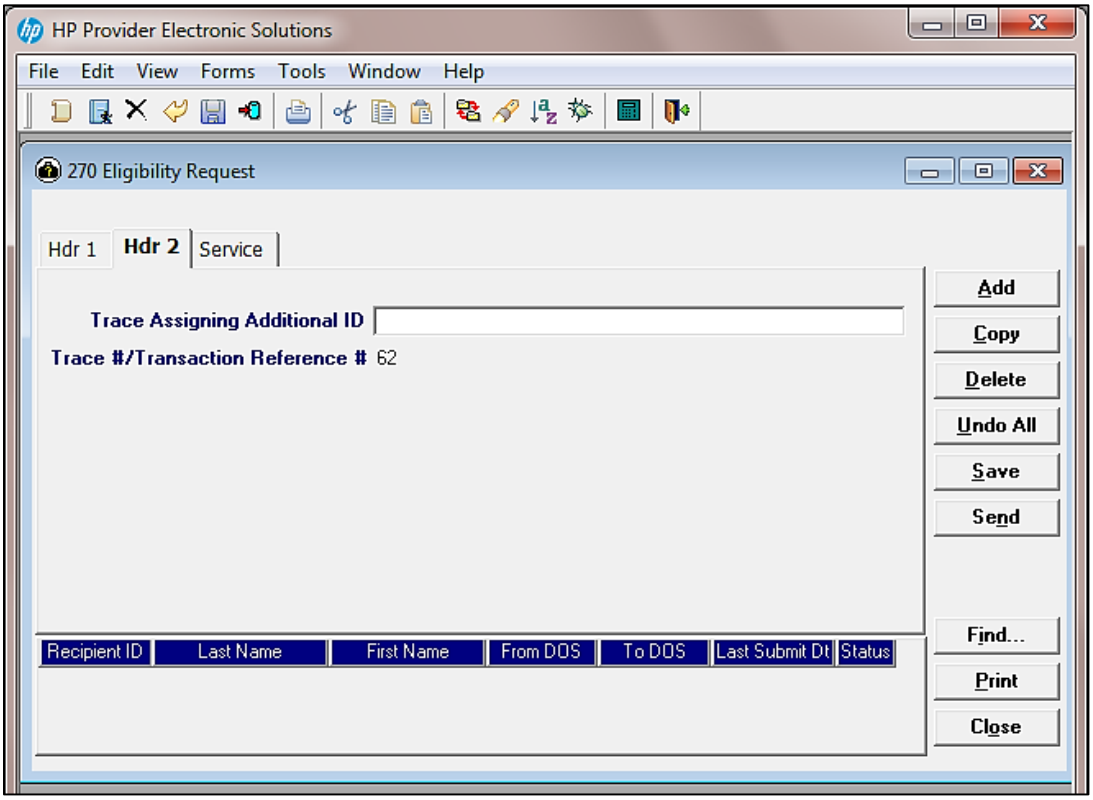
Step 3. Click Save to save the 270 Eligibility Request.

Step 4. Click Add to start another 270 Eligibility Request.

or

Step 5. Click Close to exit the 270 Eligibility Request form.

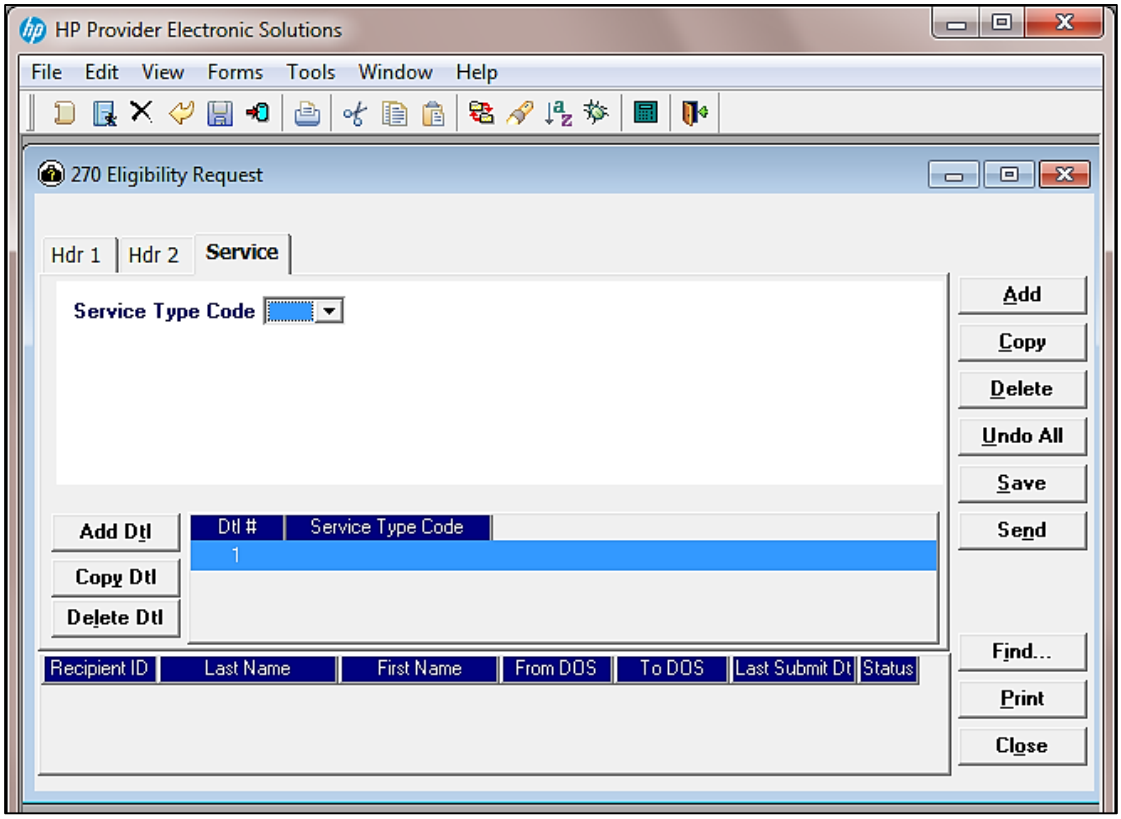
Step 6. Complete Header 2.



Header Two contains the data being verified for eligibility. To complete the Header 2 screen:

Trace Assigning Additional ID	Enter the Trace Assigning Additional ID of the department, person, or group in your office that is sending the 270 Eligibility Request. Information placed in this field is included on the 271 Eligibility Responses that assist you in matching the 271 Eligibility Responses to the department, person, or group in your office who made the eligibility request.
Trace #/Transaction Reference #	Used by the software to match the 270 Eligibility Request with the 271 Eligibility Response. This value automatically increases by 1 each time a new 271 Eligibility Response is generated.

Step 7. Complete Service.



Service contains the Service Type Code. To complete the Service screen:

Service Type Code	Health Benefit Plan Coverage - **Required if utilizing a Service Type Code inquiry**– list of codes supported is in Appendix B Values may be repeated 99 times.

Step 8. Click Add Dtl to add another detail line,

Step 9. A new blank detail line is added to the screen.
Step 10. Click on the new detail line, and then enter the data in the appropriate data fields.
Step 11. Click Copy Dtl to copy the data from an existing detail line to a new detail line.
Step 12. A new detail line is added to the screen.
Step 13. The new detail line has the same data as the existing detail line you previously selected. You can edit the data in the new detail line.
Step 14. Click on the new detail line to make changes to the appropriate fields.
Step 15. Click Delete Dtl to delete an existing detail line.
Step 16. The selected detail line is deleted.
Step 17. Click Save to save the 270 Eligibility Request.
Step 18. Click Add to start another 270 Eligibility Request.

or

Click Close to exit the 270 Eligibility Request form.

9.2 Submit a 270 Eligibility Request

The 270 Eligibility Request is submitted in either an interactive mode or a batch mode. These modes are described in this section.

9.2.1 Interactive Submission

An interactive submission is when a single request is entered and a response is received back within a few minutes after the request is submitted.

> **Note:** PES provides a Web-based Interactive communication method. In order to use the Web/BBS for Interactive claims choose W for Web (B for BBS is no longer available) on the Tools, Options – Web screen: For instructions go to Section 5.1 Web – Internet in the *Provider Electronic Solutions Software User's Manual*.

To submit an interactive 270 Eligibility Request, perform the following steps:

Step 1. Complete the 270 Eligibility Request as directed in Section 9.1.
Step 2. Click Save.
Step 3. Click Send.

The Eligibility Verification System (EVS) responds to your 270 Eligibility Request by sending a 271 Eligibility Response within a few minutes of receiving your request.

Interpret the 271 Eligibility Response

The 271 Eligibility Responses identifies the recipient's eligibility for MA. Use the scroll bars (located on the right side and bottom of the 271 Eligibility Response box) to view the 271 Eligibility Responses.

An explanation of Indicated 271 Response Report Areas is listed here:

Information Source Last/ Org Name:	Indicates who has returned the 271 Eligibility responses. In this case, it is always the Pennsylvania DHS.
Service Provider Number:	Provider and service location number is used to request recipient eligibility information.
Recipient Information	Indicates recipient demographic information. First and last name, recipient ID number, date of birth, and gender are returned with the recipient information in PROMISe™.
Eligibility Benefit Information:	Eligibility benefit information on record for the recipient.

"Information not listed" indicates that the recipient does not currently have that particular benefit information on their record (MCO, TPL, Lock In, etc.).

Benefit Information areas start with "Eligibility or Benefit Information:" and end with "Last/Org Name:" A list of all possible responses is included in **Appendix B**.

Eligibility or benefit information can list Medicaid as the insurance type code because the recipient is enrolled in Pennsylvania MA. This section also includes service program information related to the recipient's enrollment.

Eligibility or Benefit Information:	Eligibility benefit information on record for the recipient. Active services indicate that the recipient is eligible for services on the date requested.
Insurance Type Code:	Recipient's coverage type. Health Maintenance Organization indicates that the recipient is enrolled in one of the Managed Care plans.
Eligibility Date:	Date a recipient is eligible for the benefit information listed.
Free-Form Message Text:	Primary care provider listed on the recipient's record.
Last/Org Name:	Organization indicated in the Eligibility or Benefit Information line.
Plan Coverage Description:	Recipient's service program. Consult the latest Health Care Benefits Package information to determine the recipient's level of coverage.

When a 270 request cannot be processed, an error message is returned instead of a 271 response. A list of the currently used error codes is included in **Appendix B**.

Note: Always select the 999 Acknowledgement(s), Accepted Submit Report(s), Rejected Submit Report(s) and Submission Transaction Report(s) for the files to receive.

9.2.2 Batch Submission

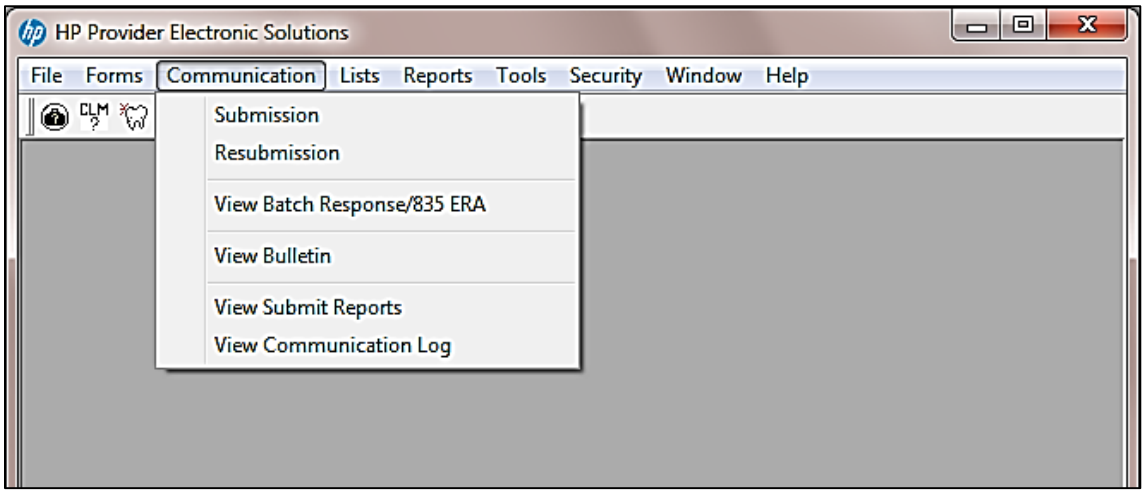
Batch Submission means that an inquiry is submitted as a group with other form types. A batch transmission lets you enter multiple requests and submit them to HP Enterprise Services to be processed overnight for the next day of service. In order to access the Web System (BBS) for Batch Eligibility submissions, a valid, live BBS Logon ID and password are required. To obtain these IDs, please register at

http://www.dhs.state.pa.us/provider/promise/certification/index.htm

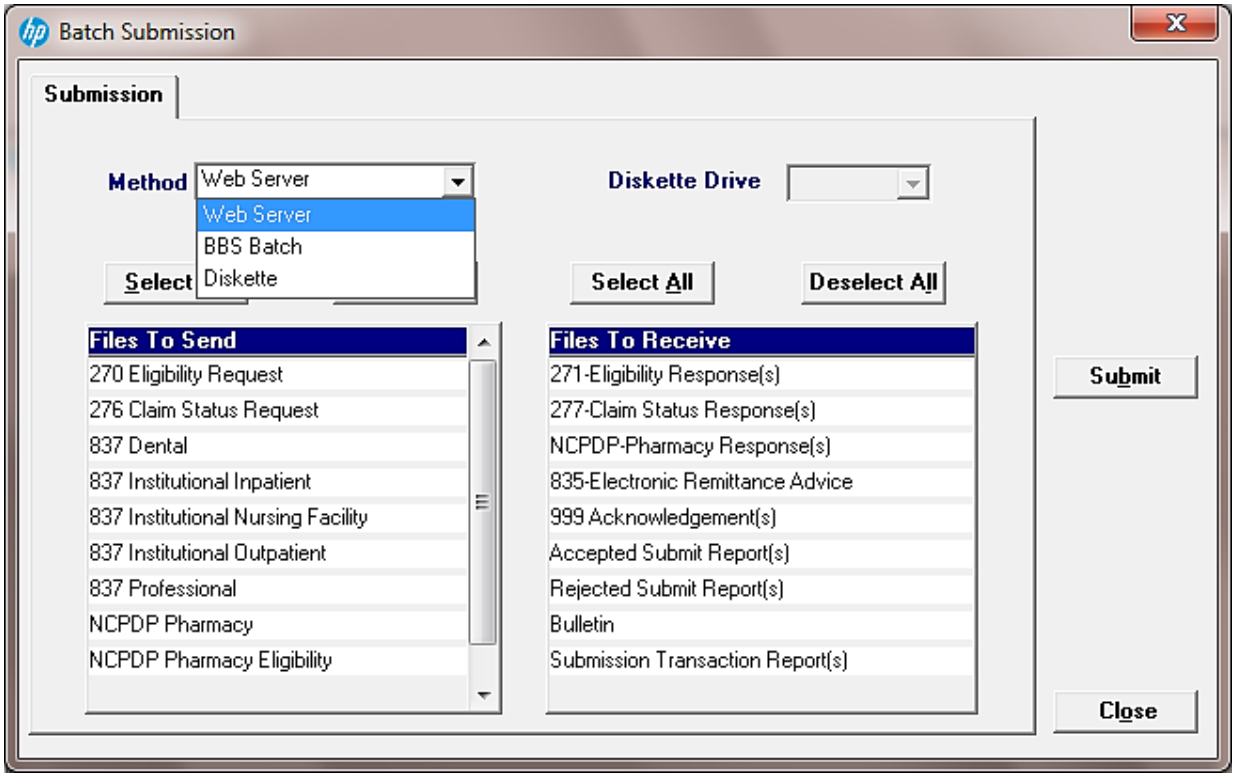
To submit a batch 270 Eligibility Request, perform the following steps:

Note: You must choose the Web Server option (BBS Batch option is no longer available) to send the files.

Complete the 270 Eligibility Request as directed in Section 9.1 Complete a 270 Eligibility Request, of the *Provider Electronic Solutions Software User's Manual*.



Note: You can enter as many 270 Eligibility Requests as needed at one time. All requests in an "R" status are sent at one time.



Step 1. Select the method Web Server to send the file(s) for Processing in the **Method** drop down box. This must be the same method you listed in the Tools and Options of the PES software.

Note: BBS Batch and Diskette are no longer available.

Step 2. Select the forms you want to submit from the **Files to Send** column.

Step 3. Click Submit.

Submitting forms by batch lets you submit several form types at the same time. However, only the 270 Eligibility Request is processed for the next day of service. The system accepts the 270 Eligibility Request files you sent, and on the next day of service, processes them and places a 271 Eligibility Response(s) on the bulletin board.

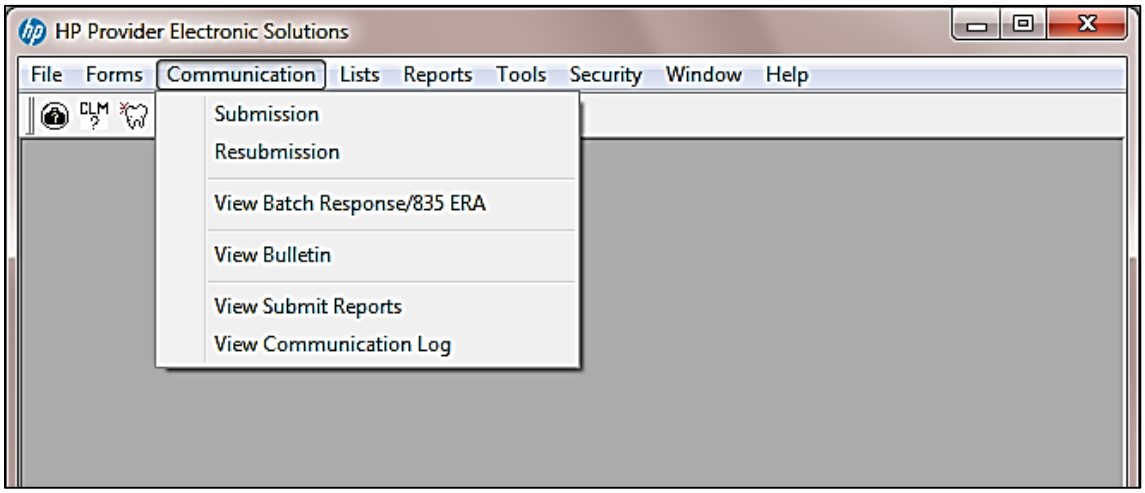
For example, if you submit a batch of 270 Eligibility Request forms on January 2nd, the system processes your request and has a 271 Eligibility Response available for you to access on January 3rd.

Step 4. When you receive an Application box that identifies the status of your transmission, read the message and click OK.

If the transmission was unsuccessful, read the message or communication log, make the necessary changes, and resubmit the files.

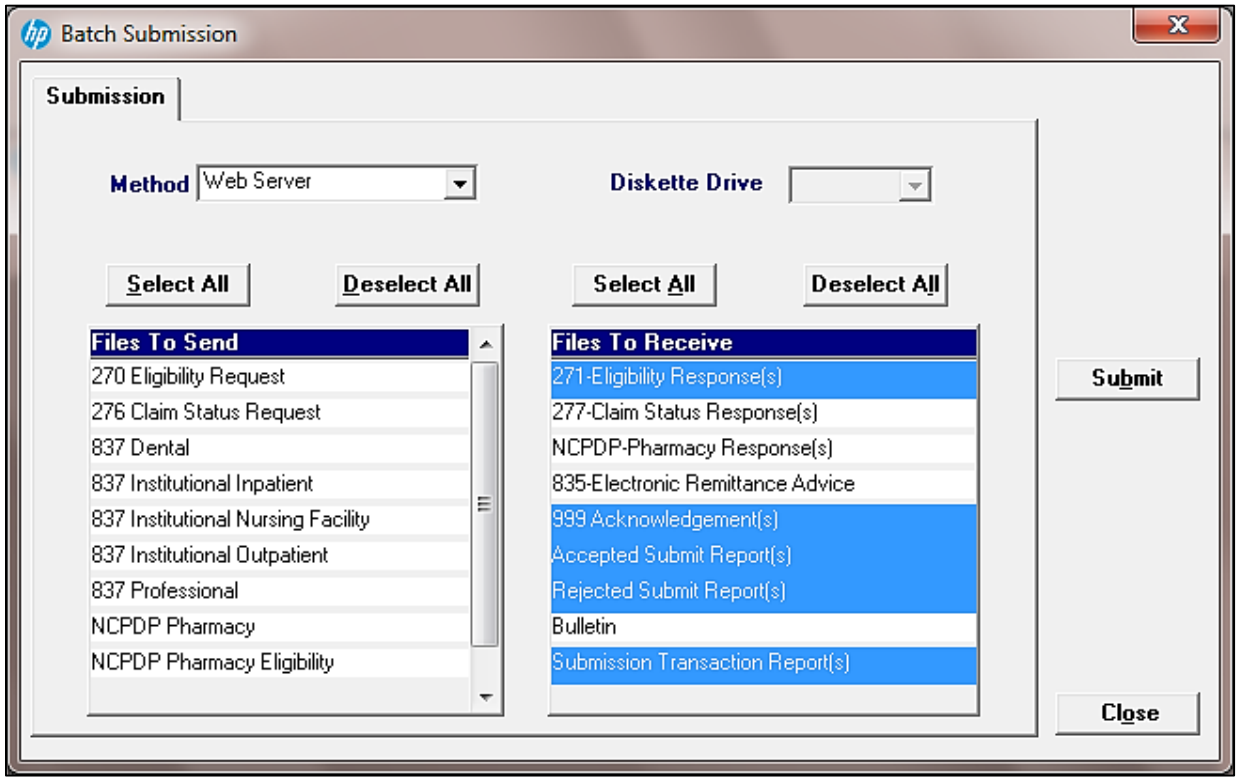
The following day:

Step 5. Select the **Communication/Submission** option from the main screen.



Step 6. Select the form files you want to receive located under the Files to Receive column.

Note: Always select the Submission Transaction Report(s), 999 Acknowledgment(s), Accepted Submit Report(s) and Rejected Submit Report(s) for the files to receive, along with the 271-Eligibility Response(s). Review all the Reports to make sure all submissions were processed.



Note: Keep in mind that submitting by batch lets you receive several form types at the same time. Although you can receive several form types simultaneously, only the 270 Eligibility Request forms are processed for the next day of service.

Step 7. Click Submit.

Note: If the transmission was unsuccessful, read the message or communication log, make the necessary changes, and resubmit the files.

Step 8. **Select the 999 Acknowledgment(s), Accepted Submit Report(s), Rejected Submit Report(s) and Submission Transaction Report(s).**

Note: These reports help determine what errors were encountered in processing the submitted file.

View Batch Response/835 ERA

The View Batch Response/835 ERA option allow you to view and print a 271 Eligibility Responses or an 835 Electronic Remittance Advices (ERA).

Note: CARC - Claim Adjustment Reason Codes
RARC – Remittance Advice Remark Codes

Additional information is located at the following links.

******* For complete CARC/RARC Descriptions, please visit the following web site: *******

Washington Publishing Company **http://www.wpc-edi.com**

CAQH CORE website **http://www.caqh.org**

Step 1. Select the **Communication/View Batch Response/835 ERA** option from the main screen.

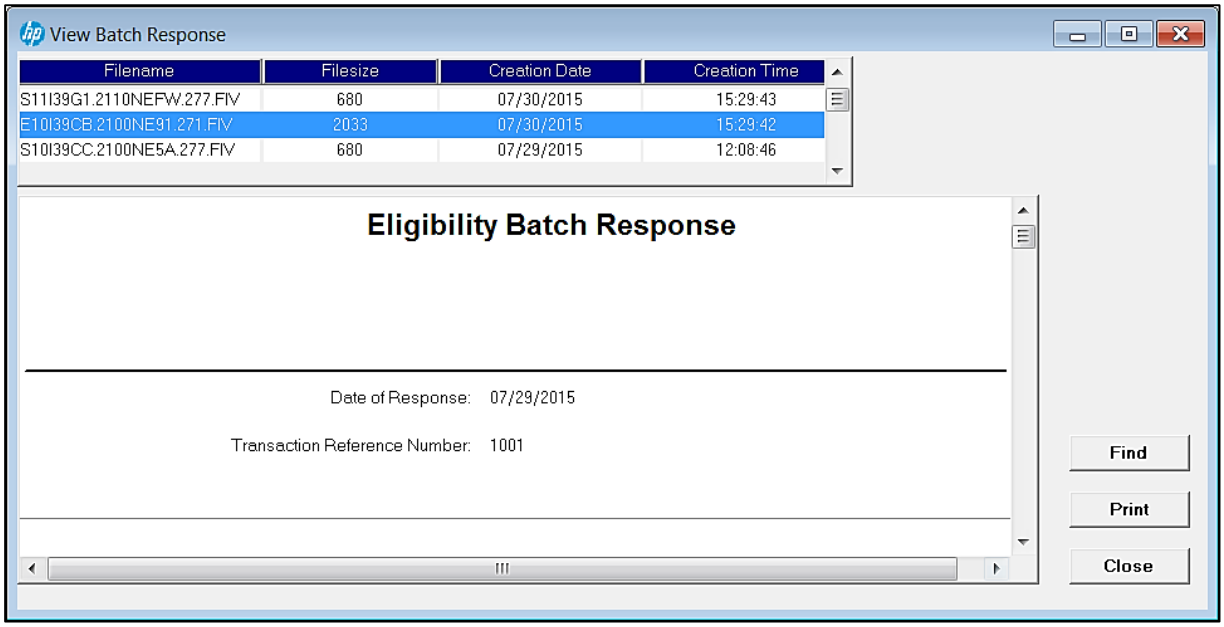
Step 2. Click the corresponding filename listed under the Filename column to view a particular batch.

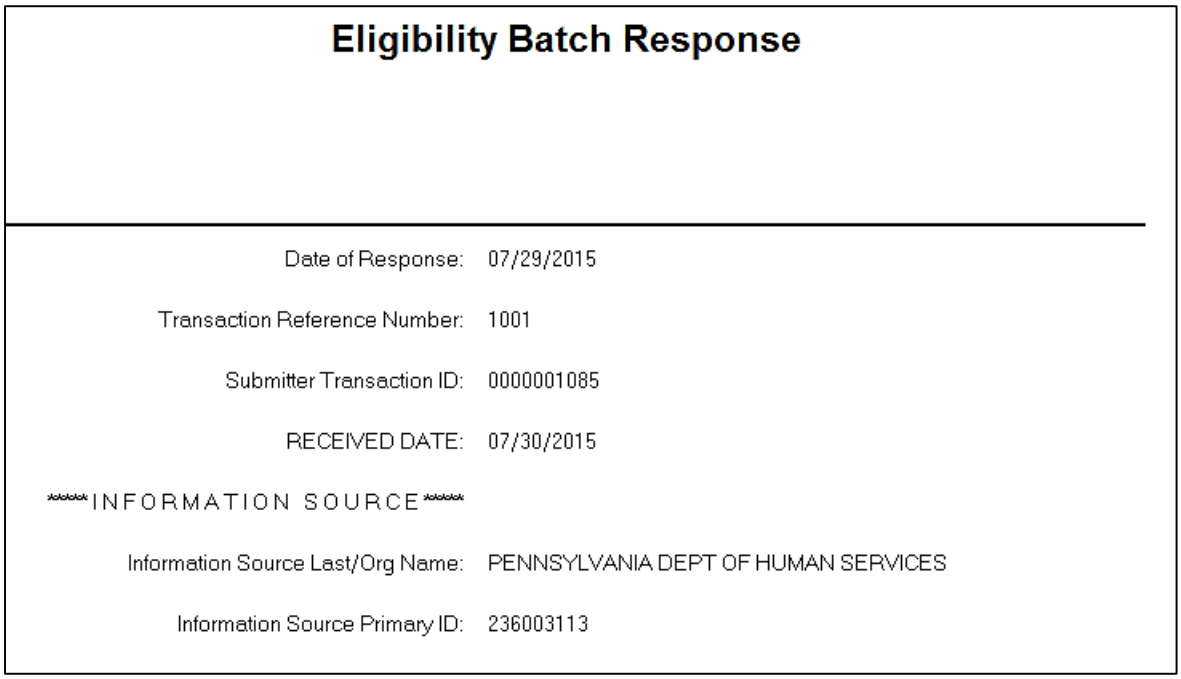
Step 3. Use the scroll bar to view the batch response

or

Press Print to print the 271 Eligibility Responses.

Each form is assigned a transaction reference number, which indicates the beginning of a new 271 Eligibility Response.




Eligibility Batch Response
Date of Response: 07/29/2015
Transaction Reference Number: 1001
Submitter Transaction ID: 0000001085
RECEIVED DATE: 07/30/2015
*****INFORMATION SOURCE*****
Information Source Last/Org Name: PENNSYLVANIA DEPT OF HUMAN SERVICES
Information Source Primary ID: 236003113

Step 4. Click

, to exit the View Batch Response box.

9.3 Complete the 276 Claim Status Request

The 276 Claim Status Inquiry Request form is used to create a request to determine claim status and is submitted in either an interactive mode or a batch mode. These modes are described in this section.

The 276 Form is divided into two screens. Each screen contains the following claim data:

Header 1 – This tab contains the provider and recipient information

Header 2 – This tab contains the specific claim information

For additional information on a particular field, highlight the field with your mouse and press **F1.**

To create a claim status request, perform the following steps:

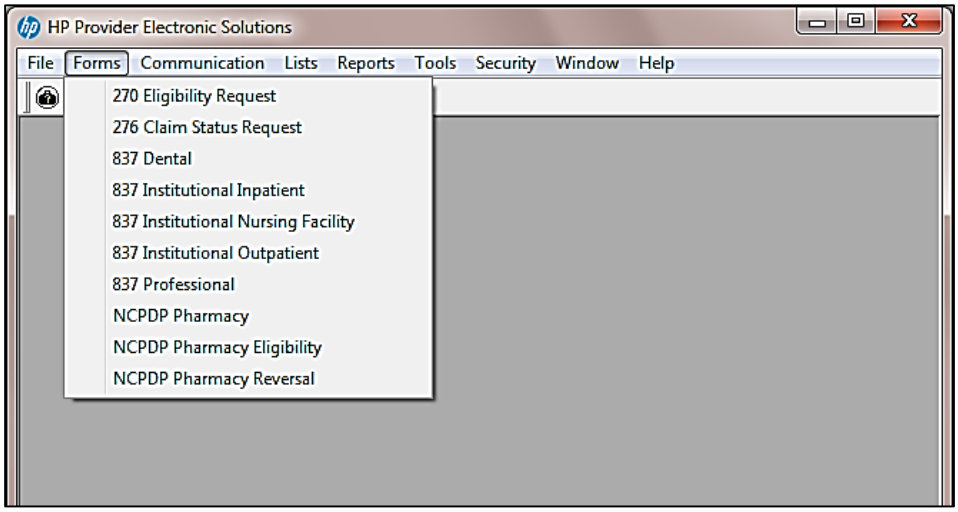
Step 1. From the Provider Electronic Solutions software main screen, access the 276 Claim Status Inquiry Request in one of the following two ways:

Click

(276 Claim Status Inquiry Request Shortcut Button) on the Toolbar

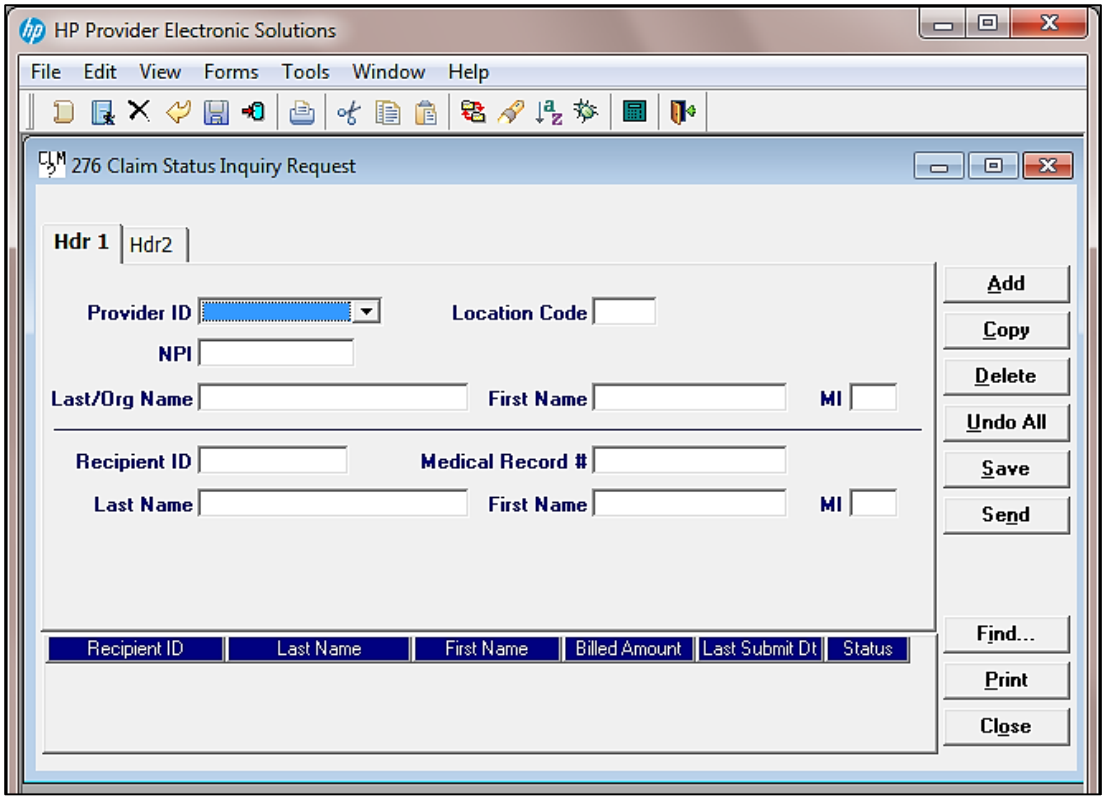
or

Select the 276 Claim Status Inquiry Option from the Forms drop down menu, as shown below.



Choosing a selection from a drop down list, as indicated in the field completion instructions below, completes many of the fields. A drop down list is also known as a reference list. For additional information on reference lists, refer to the Lists options under Section 6.

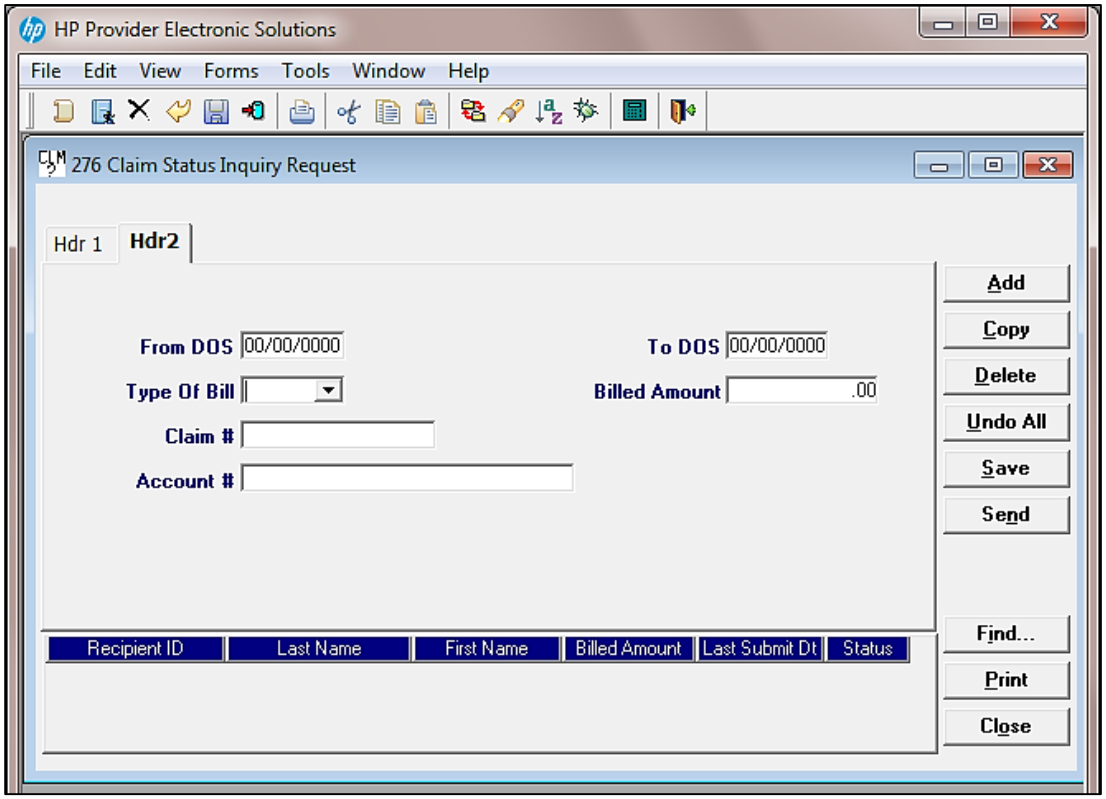
Step 2. Complete Header 1.



Provider ID	Select the 9-digit MPI number from the drop down box or enter an appropriate value as specified that was used to bill the submitted claim.
Location Code	Enter the 4-digit location code that was used to bill the submitted claim. This field is automatically populated after a Provider ID is submitted.
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name	Provider's last name or the group name. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Provider List Form.*
First Name (Provider ID)	Provider's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Provider List Form.*
MI	Recipient's middle initial. This field is automatically populated after you select or enter a recipient number.

	Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.
Recipient ID	Select the 10-digit recipient ID number from the drop down list or enter an appropriate value as specified.
Medical Record #	Field is automatically populated once a recipient ID is selected.
Last Name	Recipient's last name. This field is automatically populated after you select or enter a Recipient number in the Recipient ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Recipient List Form.*
First Name	Recipient's first name. This field is automatically populated after you select or enter a recipient number in the Recipient ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Recipient List Form.*
MI	Recipient's middle initial. This field is automatically populated after you select or enter a recipient number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*

Step 3. Complete Header 2.



From DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient first received service under this claim. For example, enter 10012015 if the date was October 1, 2015. If the same service was provided on a single day, enter the date of service in both the From DOS and To DOS fields.
To DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient last received service under this claim. For example, enter 10012015 if the date was October 1, 2015.
Type Of Bill	Enter the type of bill code, or enter the appropriate value based on your facility and bill type.
Billed Amount	Enter the amount (using a decimal point) usually charged to the self-paying public for the service(s) provided. If billing for multiple units, multiply the usual charge by the number of units billed and enter that amount. Zero (0) billed amount is a permitted value.
Claim #	Enter the Original ICN as printed on the RA.

Account #	Enter the account number assigned to the recipient by the provider for the service that was performed. This information is returned on the RA statement. A unique account number is required for each claim submitted to be able to obtain claim status information. If the same account number is used for each claim submitted when a claim status request is sent, the claim status is reported on **all** claims with that account number.
Claim status can only be obtained for claims submitted after the implementation of PA PROMISe™.	

Step 4. Click Save to save the form.

Step 5. Click Add to start another claim status inquiry, or

Step 6. Click Close to exit the 276 Claim Status Inquiry form.

9.3.1 Interactive Submission

An interactive submission is when a single request is entered and a response is received back within a few minutes after the request is submitted.

Note: PES provides a Web-based Interactive communication method. In order to use the Web/BBS for Interactive claims choose W for Web (B for BBS is no longer available) on the Tools, Options – Web screen: For instructions go to Section 5.1 Web – Internet in the *Provider Electronic Solutions Software User's Manual*.

To submit an interactive 276 Claim Status Inquiry Request, perform the following steps:

Step 1. Complete the 276 Claim Status Inquiry Request as directed in Section 9.3.1.

Step 2. Click .

Step 3. Click .

The system responds to your 276 Claim Status Inquiry Request by sending a 277 Claim Status Response within a few minutes of receiving your request.

Note: If the transmission was unsuccessful, read the message or communication log, make the necessary changes, and resubmit the files.

Step 4. Select the 999 Acknowledgment(s), Accepted Submit Report(s), Rejected Submit Report(s) and Submission Transaction Report(s) and access the system again if no file is found and the submission was successful. At this time you can also click on the 277-Claim Status Response(s).

Note: These reports help determine what errors were encountered in processing the submitted file.

View Batch Response/835 ERA

The View Batch Response/835 ERA option allow you to view and print a 271 Eligibility Responses or an 835 Electronic Remittance Advices (ERA).

Note: CARC - Claim Adjustment Reason Codes
RARC – Remittance Advice Remark Codes

Additional information is located at the following links.

******* For complete CARC/RARC Descriptions, please visit the following web site: *******

Washington Publishing Company **http://www.wpc-edi.com**

CAQH CORE website **http://www.caqh.org**

Step 5. Select the **Communication/View Batch Response/835 ERA** option from the main screen.

Step 6. Click the corresponding filename listed under the Filename column to view a particular batch.

Step 7. Use the scroll bar to view the batch response

or

Press

to print the 277 Claim Status Inquiry Responses.

Each form is assigned a transaction reference number, which indicates the beginning of a new 277 Claim Status Inquiry Response.

9.4 Complete the 837 Dental Form

The 837 Dental Form is used to create claims for dental services. The 837 Dental Form is divided into seven screens. Each screen contains the following claim data:

Hdr 1	Accesses the screen that contains the provider and recipient information.
Hdr 2	Accesses the screen that contains ICD Version, Diagnosis Codes and orthodontic treatment information.
Hdr 3	Accesses the screen that contains accident, rendering provider, and service facility location information.
Hdr 4	Access the screen that contains the From DOS, To DOS, referring provider and the Supervising Provider information.
Other Insurance (OI)	Accesses the screen that contains other insurance carrier information and can be accessed by selecting **Y,** in the Other Insurance Ind field, located under the Header 3 tab.
Srv 1	Accesses the screen that contains service information.

Srv 2	Accesses the screen that contains miscellaneous treatment information.
Service Adjustment (Srv Adj)	Accesses the screen that contains third party insurance carrier adjustment information. It can be accessed by selecting **Y** in the Other Insurance Ind field located under the Header 3 tab, then selecting **Y** in the Service Adjustment Ind field located under the Service 2 tab.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

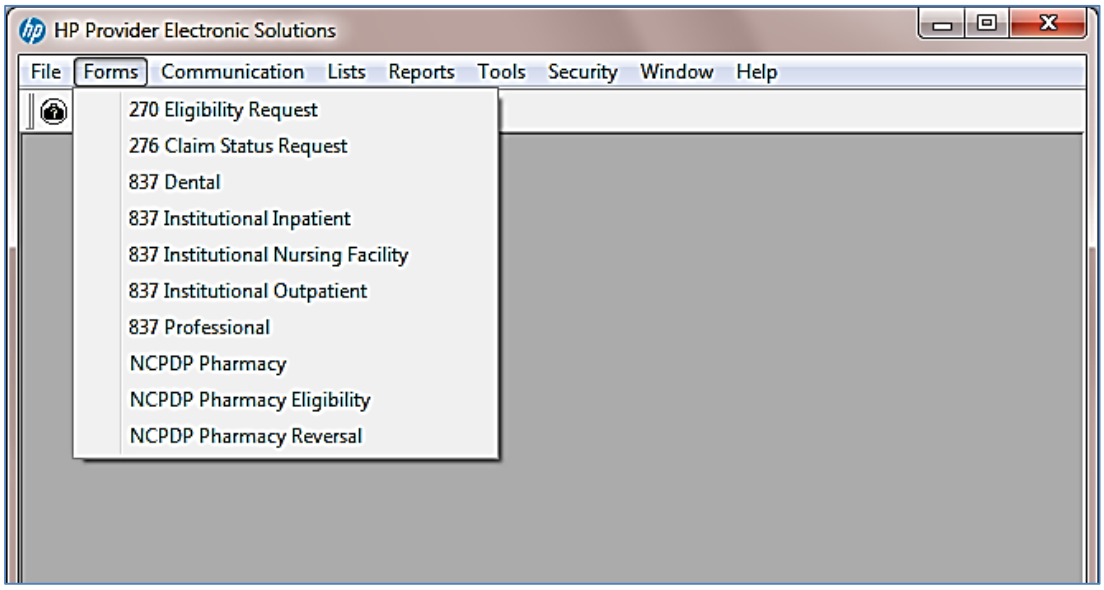
To create a dental claim, perform the following steps:

Step 1. From the Provider Electronic Solutions software main screen access the 837 Dental Form in one of the following two ways:

Click (837 Dental Shortcut Button) on the Toolbar

or

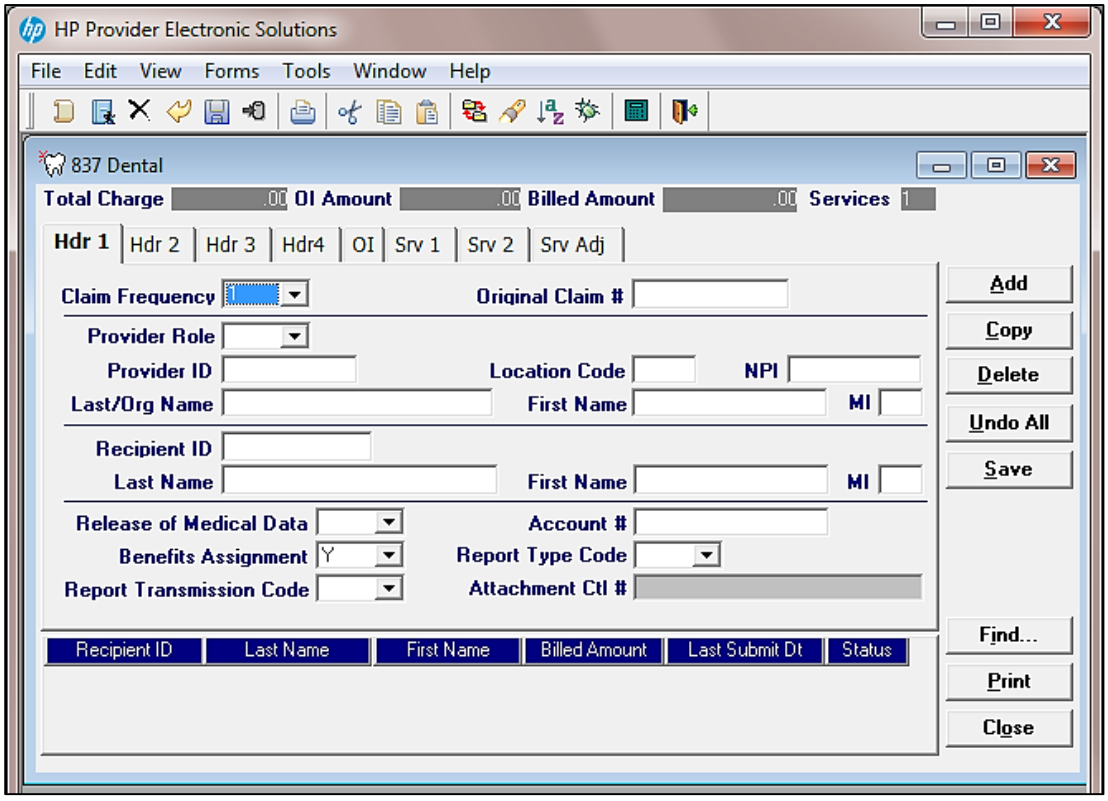
Select the **837 Dental Option** from the **Forms** drop down menu, as shown below.



Choosing a selection from a drop down list, as indicated in the field completion instructions below, completes many of the fields. A drop down list is also known as a reference list. For additional information on reference lists, refer to the List options under Section 6.

The 837 Dental Form appears, with the Header 1 screen displayed, as shown.

Step 2. Complete Header 1.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Dental
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr4 OI Srv 1 Srv 2 Srv Adj
Claim Frequency 1 Original Claim #
Provider Role
Provider ID Location Code NPI
Last/Org Name First Name MI
Recipient ID
Last Name First Name MI
Release of Medical Data Account #
Benefits Assignment Y Report Type Code
Report Transmission Code Attachment Ctl #
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

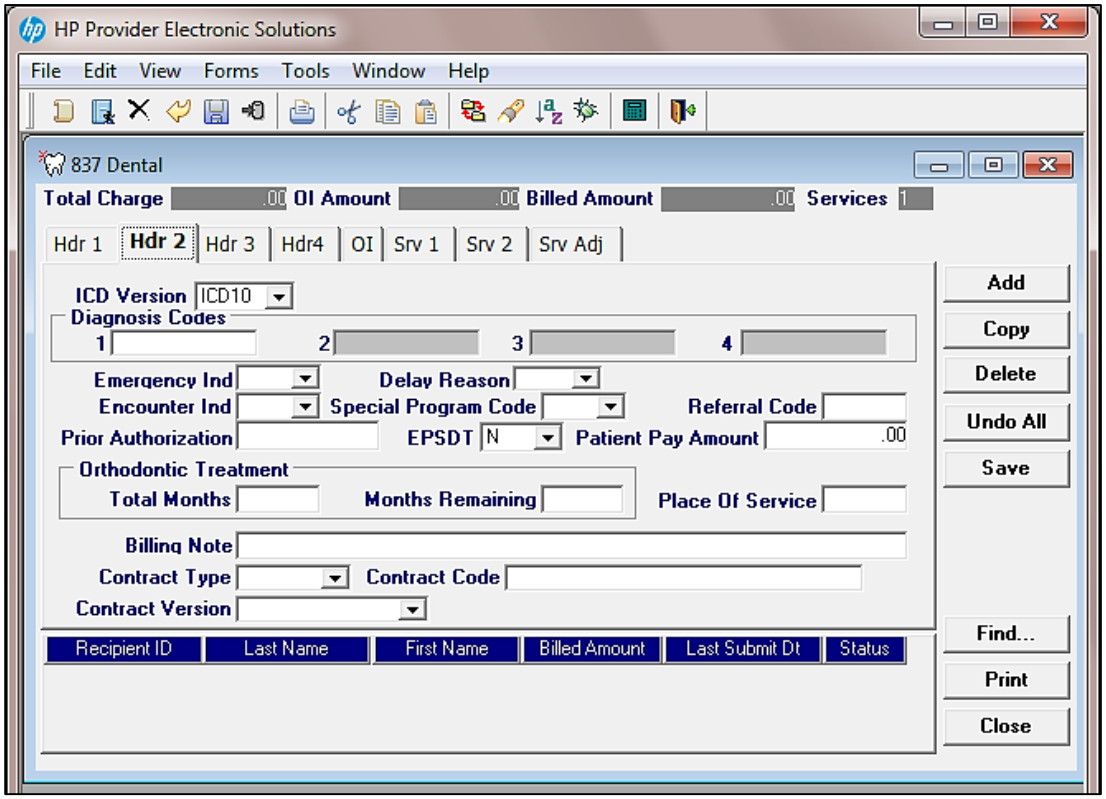
Claim Frequency	Frequency in which the claim is/was submitted. Select the appropriate frequency code from the drop down list, as described below or enter an appropriate value as specified:	
	0 – No Pay Claim	This code should be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill.
	1 - Original (Admit thru Discharge Claim)	Code is used to bill new or previously unpaid service to MA. You may also use this code to resubmit a bill that was rejected on a RA.
	7 - Replacement (Replacement of Prior Claim)	Code is used when a specific bill was paid and needs to be replaced or adjusted.
	8 - Void (Void/Cancel of Prior Claim)	Code reflects the elimination or the backing out in its entirety of a previously submitted bill for a specific provider, patient, payer, insured, and statement covers period dates.

Original Claim #	Enter the Original ICN as printed on the RA.
If you are resubmitting or adjusting a claim processed **prior** to the implementation of PA PROMISe™, enter the 10-digit claim reference number (CRN) followed by the 2-digit line number.	
Provider Role	Select the provider role code from the drop down list or enter an appropriate value as specified, as described below. Select **1**, if the provider number entered is for a group practice. Select **2**, if the provider number entered is for an individual provider.
Provider ID	Select the 9-digit Master Provider Index (MPI) number (**PROMISe™ Legacy Numbers)** for the provider that the claim is paid under, from the drop down list or double-click on the data entry portion of the field to add a reference list selection. If assigning payment to a group, select the 9-digit group MPI number.
Location Code	Field automatically completes once a provider ID number is selected or entered. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Provider List Form.*
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name	Provider's last name or the group name. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Provider List Form.*
First Name	Provider's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Provider List Form.*
MI	Provider's middle initial. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Provider List Form.*
Recipient ID	Select the recipient's 10-digit recipient number. For additional information on the Recipient ID field, refer to the "Complete a Recipient reference list," heading, found in Section 8 of the *Provider Electronic Solutions software*

	User's Guide. Information cannot be entered directly into these fields, to add or change information in these fields, access the Recipient List Form.
Last Name	Recipient's last name. This field is automatically populated after you select or enter a Recipient number in the Recipient ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Recipient List Form.*
First Name	Recipient's first name. This field is automatically populated after you select or enter a recipient number in the Recipient ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Recipient List Form.*
MI	Recipient's middle initial. This field is automatically populated after you select or enter a recipient number in the Recipient ID field. *Information cannot be entered directly into these fields, to add or change information in these fields, access the Recipient List Form.*
Release of Medical Data	Select the appropriate release code from the drop down list or enter an appropriate value as specified: Select **I**, if the provider has Informed Consent to Release Medical Information. Select **Y**, if the provider has a signed statement on file permitting the release of medical data to other organizations.
Account Number	Enter the patient's alpha, numeric, or alphanumeric number assigned by the provider. You may enter up to 30 characters. MA captures and returns 30 characters. When this field is completed, the patient's account number appears on the RA statement, and makes it easier to identify those invoices where the recipient number is not recognized. **Note:** An account number is required for each claim to be able to obtain claim status information. If the same account number is used for each claim submitted, when a claim status request is sent, the claim status is reported on **all** claims with that account number.
Benefits Assignment	Select the appropriate assignment code from the drop down list or enter an appropriate value as specified: Select **Y**, if the recipient, or authorized person has authorized benefits to be assigned to the provider. Select **N**, if the recipient or authorized person does not have authorized benefits to be assigned to the provider.

	Select **W** for Not Applicable – Not applicable for this claim.	
Report Type Code	Enter the appropriate code for the type of attachment submitted from the drop down or enter an appropriate value as specified:	
	B4 – Referral Form **DA** – Dental Models **DG** – Diagnostic Report **EB** – Explanation of Benefits	**OB** – Operative Notes **OZ** – Support Data for Claim **P6** – Periodontal Charts **RB** – Radiology Films **RR** – Radiology Reports
Report Transmission Code	Enter the appropriate code for the method of attachment transmission from the drop down or enter an appropriate value as specified:: **AA** – Available on Request at Provider Site **BM** – By Mail **EL** – Electronically Only **EM** – E-Mail **FX** – By Fax	
Attachment Control	Enter the (up to) 10-digit number obtained from the PROMISe™ web site. This number is used when a paper attachment is required by MA to cross-reference the paper attachment with the electronic claim. This number also must be written on the cover letter sent to MA.	

Step 3. Complete Header 2.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Dental
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr4 OI Srv 1 Srv 2 Srv Adj
ICD Version ICD10
Diagnosis Codes
1 2 3 4
Emergency Ind Delay Reason
Encounter Ind Special Program Code Referral Code
Prior Authorization EPSDT N Patient Pay Amount .00
Orthodontic Treatment
Total Months Months Remaining Place Of Service
Billing Note
Contract Type Contract Code
Contract Version
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

Diagnosis Codes	Enter the most specific diagnosis ICD-9-CM/ICD-10-CM/PCS code that relates to the recipient's visit.	
ICD Version	Use the ICD-9/ICD10 Version for the code being submitted.	
Emergency Indicator	Select the appropriate Emergency Indicator code from the drop down list or enter an appropriate value as specified. Select **3**, if the service provided was in response to an emergency	
Delay Reason	Select the appropriate code to indicate why a claim is being submitted outside of the 180-day initial submission window (field is optional) or enter an appropriate value as specified:	
	1 – Proof of Eligibility Unknown or Unavailable **2** – Litigation **3** – Authorization Delays **4** – Delay in Certifying Provider **5** – Delay in Supplying Billing Forms	**7** – Third Party Processing Delay **8** – Delay in Eligibility Determination **9** – Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules **10** – Administration Delay in the Prior Approval Process

	6 – Delay in Delivery of Custom Made Appliances	**11** – Other
Encounter Ind	Enter the correct Encounter Indicator information. **RP** – Reporting - Used only when the claim is submitted as an encounter by a managed care organization (MCO). **CH** – Chargeable - Used when billing for payment. **Note:** Consolidated Community Reporting for OMHSAS (CCR) encounter submissions are indicated using the Encounter Ind. To submit an encounter, select "RP" from the field's drop down list.	
Special Program Code	The special program code indicates the claim was submitted under one of the circumstances, programs, or projects listed. Select the appropriate value from the drop down list or enter an appropriate value as specified. **02** – Physically Handicapped Children's Program **03** – Special Federal Funding **05** – Disability	
Referral Code	Enter the 2-digit Primary Care Case Manager Referral code. For claims that have a referring provider, but do not have a Referral code, enter the referring provider's license number. Not currently used.	
Prior Authorization	Enter the appropriate 10-digit certification or authorization number, as described below: Enter the 10-digit Prior Authorization number if the service requires and has received prior authorization. Enter the 10-digit Prior Authorization number for approved 1150 Administrative Waiver services.	
EPSDT	Select the EPSDT code from the drop down list or enter an appropriate value as specified, as described below: Select **Y**, if the recipient participates in the Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Select **N**, if the recipient does not participate in the Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.	
Patient Pay Amount	Enter the amount (use a decimal point) that the recipient has paid toward his/her medical bills, as determined by the local County Assistance Office (CAO). Patient pay is only applicable if notification is received from the local CAO on a PA 162RM. For	

	example, enter 25.50 if the amount was $25.50. **Do not enter copay in this field.**
Orthodontic Treatment (Total Months)	Enter the total number of months the recipient has received orthodontic treatment.
Orthodontic Treatment (Months Remaining)	Enter the total number of orthodontic treatment months remaining for the transfer recipient.
Place of Service	Select the Place Of Service code from the drop down list or enter an appropriate value as specified. The Place Of Service code identifies the location where the service was performed. The only Place Of Service fields accepted on an 837 Dental Claim are listed below: **03** – School **04** – Homeless Shelter **11** – Office, Outpatient Clinic, Independent Clinic **12** – Patient's Home or Community **15** – Mobile Unit **21** – Inpatient Hospital, **22** – Outpatient Hospital **23** – Emergency Room – Hospital **24** - Ambulatory Surgical Center/SPU **25** - Birthing Center **26** – Military Treatment Center **31** – Skilled Nursing Facility **32** – Nursing Facility **33** – Custodial Care Facility **34** – Hospice **35** – Adult Living Care Facility **41** – Ambulance - Land **42** – Ambulance – Air or Water **50** – Federally Qualified Health Center **51** – Inpatient Psychiatric Facility **52** – Psychiatric Facility Partial Hospitalization **53** – Community Mental Health Center **54** – Intermediate Care Facility/Mentally Retarded **55** – Residential Substance Abuse Treatment Facility

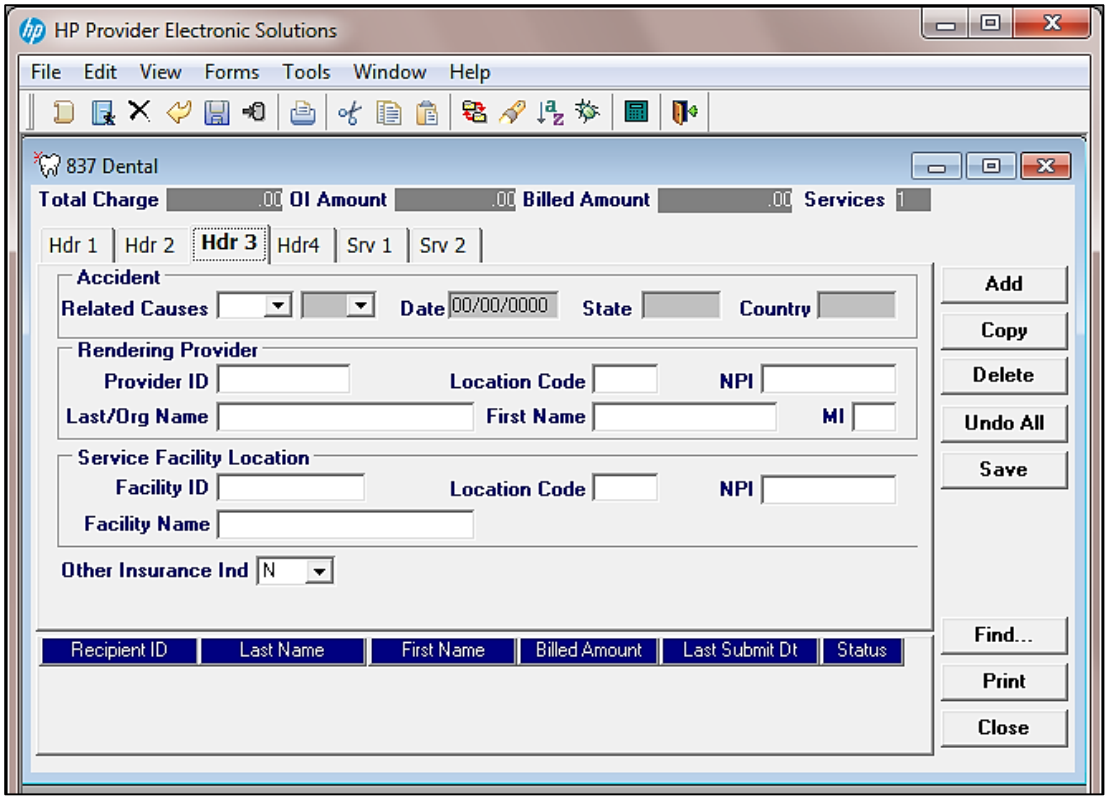
	56 – Psychiatric Residential Treatment Center **60** – Mass Immunization Center **61** – Comprehensive Inpatient Rehabilitation Facility **62** – Comprehensive Outpatient Rehabilitation Facility **65** – End Stage Renal Disease Treatment Facility **71** – State or Local Public Health Clinic **72** – Rural Health Clinic **81** – Independent Laboratory **99** – Other Unlisted Facility **Note:** If the Place of Service is used in Hdr 2, do not use a Place of Service in Srv 1 unless it is a different Place of Service.

<table>
<tr><td>Billing Note</td><td>Use this field to record visit codes necessary to adjudicate MA Claims as follows:
<table>
<tr><th>If the visit code is…</th><th>This means…</th><th>Then Enter…</th></tr>
<tr><td>09</td><td>Services rendered to a pregnant woman (Dental only)</td><td>VC09</td></tr>
<tr><td>10</td><td>Services rendered to an LTC or a state mental hospital resident</td><td>VC10</td></tr>
<tr><td>11</td><td>Provider attempted but was unsuccessful in collecting a co-payment</td><td>VC11</td></tr>
<tr><td>QSB</td><td>If the provider is a Qualified Small Business</td><td>QSB</td></tr>
<tr><td>EPSDT</td><td>If the claim involved EPSDT referral information, any of the following that apply must be entered:</td><td></td></tr>
<tr><td></td><td>EPSDT – Dental Referral</td><td>YD</td></tr>
<tr><td></td><td>EPSDT – Vision Referral</td><td>YV</td></tr>
<tr><td></td><td>EPSDT – Hearing Referral</td><td>YH</td></tr>
<tr><td></td><td>EPSDT – Medical Referral</td><td>YM</td></tr>
<tr><td></td><td>EPSDT – Behavioral Health Referral</td><td>YB</td></tr>
<tr><td></td><td>EPSDT – Other Referral</td><td>YO</td></tr>
</table></td></tr>
</table>

Note: If entering more than one code, enter them in one complete string (e.g., VC11QSBYO). Required field when claims meet the above criteria.

If the provider is a qualified small business, enter QSB in the Billing Note field. You may enter more than one code, if applicable. Example: VC09QSB for a claim filed by a qualified small business dental provider for services rendered to a pregnant woman.

Step 4. Complete Header 3.

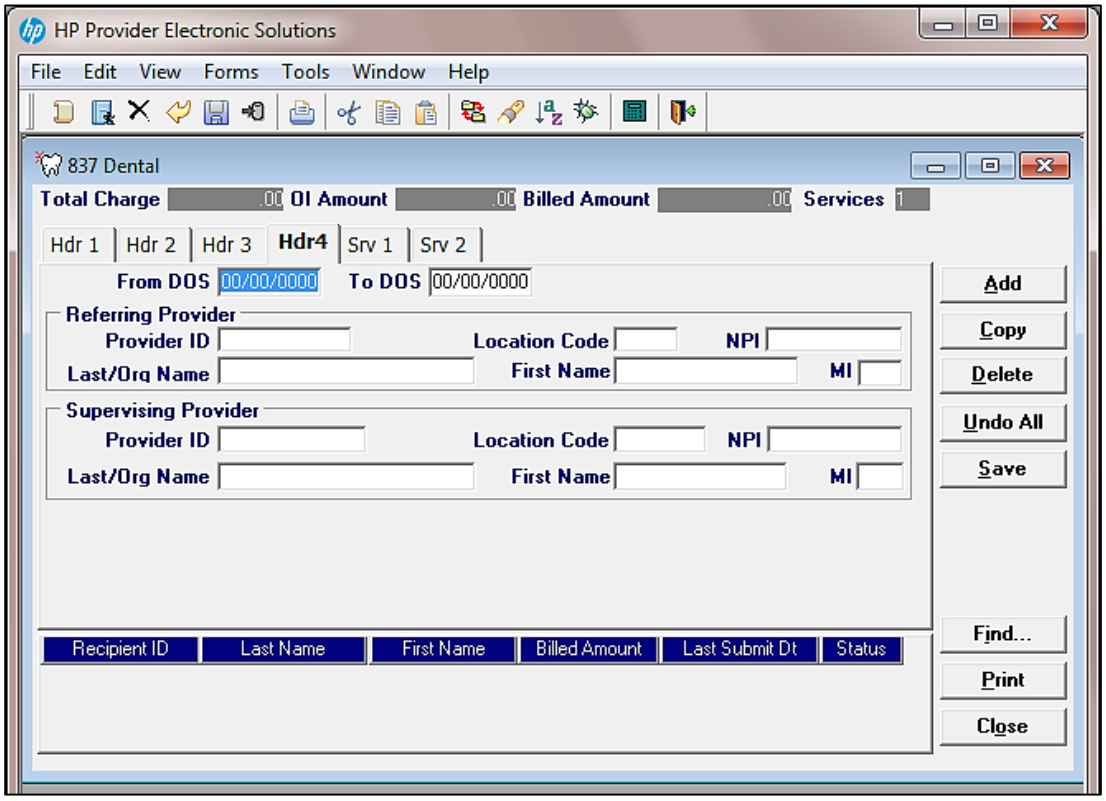


Accident – Related Causes	Select accident code from the drop down list or enter an appropriate value as specified, as described below: Select **AA**— Auto Accident - if this claim is the result of an auto accident. Select **EM —** Employment - if the claim is the result of an employment accident. Select **OA** – Other Accident - if the claim is the result of an accident other than employment or auto.
Date	Enter the 2-digit month, 2-digit day, and 4-digit year when the accident occurred that is related to the charges or to the recipient's current condition, diagnosis, or treatment. For example, enter 10012015 if the date of the accident was October 1, 2015.
State	Enter the 2-letter abbreviation for the state where the accident occurred. For example, enter **PA** for Pennsylvania.
Country	If the auto accident occurred outside the United States, enter the three-letter abbreviation for the country where the auto accident occurred. For example, enter **CAN** for Canada.

Provider ID (Rendering Provider)	Provider who rendered the service(s). Select the 9-digit MPI number for the provider of service(s), from the drop down list or double-click on the data entry portion of the field to add a reference list selection.
Location Code (Rendering Provider)	Rendering Provider's service location. This field is automatically populated after you select or enter an MPI number in the Provider ID (Rendering Provider) field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
NPI (Rendering Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Rendering Provider)	Rendering Provider's last name or group organization name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Rendering Provider) field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
First Name (Rendering Provider)	Rendering Provider's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Rendering Provider) field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
MI (Rendering Provider)	Rendering Provider's middle initial. This field is automatically populated after you select or enter an MPI number in the Provider ID (Rendering Provider) field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
Facility ID (Service Facility Location)	If the services are being rendered in an inpatient hospital, emergency room, hospital special treatment room, hospital short procedure unit, ambulatory surgical center or renal dialysis center, select the 9-digit MPI number for the Service Facility Location from the drop down list or double-click on the data entry portion of the field to add a reference list selection.

Location Code (Service Facility Location)	Code designating the provider type, classification, and specialty. This field is automatically populated after you select an MPI number from the Facility ID Field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
NPI (Service Facility Location)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Facility Name (Service Facility Location)	Name of the facility, if the services are being rendered in an inpatient hospital, emergency room, hospital special treatment room, hospital short procedure unit, ambulatory surgical center, or renal dialysis center. This field is automatically populated after you select and/or enter an MPI number in the Facility ID field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
Other Insurance Indicator	Select the other insurance code from the drop down list or enter an appropriate value as specified, as described below: Select **Y —** if the recipient has other insurance. Select **N —** if the recipient does not have other insurance.

Step 5. Complete Header 4

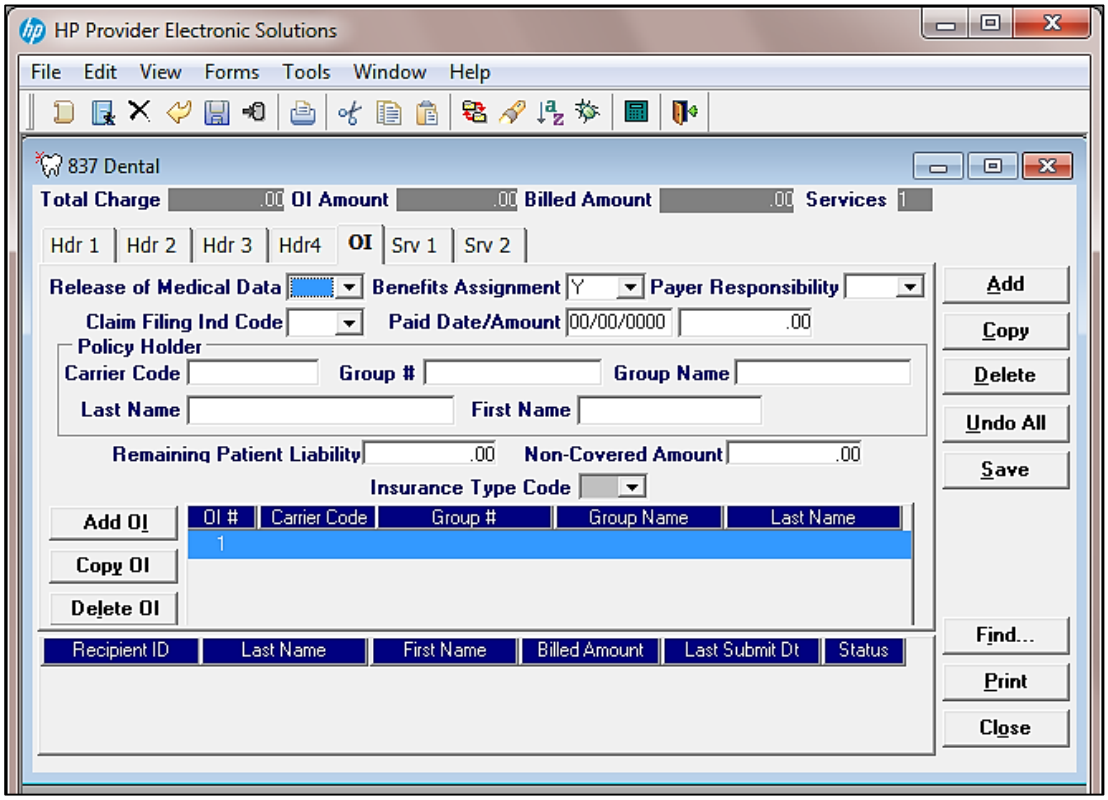

HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Dental
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr4 Srv 1 Srv 2
From DOS 00/00/0000 To DOS 00/00/0000
Referring Provider
Provider ID Location Code NPI
Last/Org Name First Name MI
Supervising Provider
Provider ID Location Code NPI
Last/Org Name First Name MI
Add
Copy
Delete
Undo All
Save
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Find...
Print
Close

From DOS	Enter the 2-digit month, 2-digit day and 4-digit year -the first day of service on which services were provided for this claim in MM/DD/CCYY format. For example, enter 10012015 if the admission date was October 1, 2015.
To DOS	Enter the 2-digit month, 2-digit day and 4-digit year the recipient last received service under this claim. For example, enter 10012015 if the date was October 1st, 2015.
Provider ID (Referring Provider)	Provider who referred the recipient for the service performed. Select the 8- or 9-digit Medical License Number, the 9-digit MPI number from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. For Access Plus Referred Services, select the 13-digit MAID number for the referring provider from the field's pull down list.
Location Code (Referring Provider)	Referring provider's 4-digit service code. This field is automatically populated after you select or enter an MPI number in the Provider ID (Referring Provider) field.

	Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.
NPI (Referring Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Referring Provider)	Referring provider's last name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Referring Provider) field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
First Name (Referring Provider)	Referring provider's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Referring Provider) field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
MI (Referring Provider)	Referring provider's middle initial. This field is automatically populated after you select or enter an MPI number in the Provider ID (Referring Provider) field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Provider List Form.*
Provider ID (Supervising Provider)	Select the 9-digit MPI number from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.- This is required when the rendering provider is supervised by a physician or dentist. Individual last name or organizational name.
Location Code (Supervising Provider)	4-digit location code associated with the MPI number selected in the Provider ID field. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*

	Required when the rendering provider is supervised by a physician or dentist.
NPI (Supervising Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position. Required when the rendering provider is supervised by a physician or dentist.
Last/Org Name (Supervising Provider)	Supervising Provider's last name or the name of the group or facility. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider.* **Required when the rendering provider is supervised by a physician or dentist.**
First Name (Supervising Provider)	Supervising provider's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID field. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form. **Required when the rendering provider is supervised by a physician or dentist.**
MI (Supervising Provider)	Supervising provider's middle initial. This field is automatically populated after you select or enter an MPI number in the Provider ID field. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form. **Required when the rendering provider is supervised by a physician or dentist.**

Step 6. Complete Other Insurance.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Dental
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr4 OI Srv 1 Srv 2
Release of Medical Data Benefits Assignment Y Payer Responsibility
Claim Filing Ind Code Paid Date/Amount 00/00/0000 .00
Policy Holder
Carrier Code Group # Group Name
Last Name First Name
Remaining Patient Liability .00 Non-Covered Amount .00
Insurance Type Code
Add OI Copy OI Delete OI
OI # Carrier Code Group # Group Name Last Name
1
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add Copy Delete Undo All Save Find... Print Close

The Other Insurance screen is added to the claim when you select **Y** in the Other Insurance Indicator field on the Header 3 screen.

Step 6.1 Click the **OI** tab to access the Other Insurance screen. The Other Insurance screen is displayed.

The Other Insurance screen contains the recipient's other insurance information for the new form.

Step 6.2 Perform the following steps to complete the **OI** screen:

Release of Medical Data	Select the release code from the drop down list or enter an appropriate value as specified, as described below: Select **I** — Informed consent to release Medical Information Select **Y** — Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim.
Benefits **Assignment**	Select the assignment code from the drop down list, or enter an appropriate value as specified, as described below: Select **Y** for Yes — if the recipient, or authorized person, has authorized benefits to be assigned to the provider.

	Select **N** for No — if the recipient, or authorized person, has not authorized benefits to be assigned to the provider. Select **W** for Not Applicable – Not applicable for this claim.	
Payer Responsibility	Payer responsible for the recipient's other insurance. Select the appropriate code from the drop down list, or enter an appropriate value as specified, as described below: **P** – Payer 1 **S** – Payer 2 **T** – Payer 3 **A** – Payer 4 **B** – Payer 5 **C** – Payer 6 **D** – Payer 7 **E** – Payer 8 **F** – Payer 9 **G** – Payer 10 **H** – Payer 11 **U** – Unknown	
Claim Filing Indicator Code	Select the appropriate claim code from the drop down list or enter an appropriate value as specified. The claim code identifies the type of other insurance claim that is being submitted.	
	MC – Medicaid **09** – Self Pay **11** – Other Non-Federal Program **12**- Preferred Provider Organization (PPO) **13**- Point of Sale (POS) **14** – Exclusive Provider Organization **15** – Indemnity Insurance **16** – Health Maintenance Organization (HMO) Medicare Risk **17** – Dental Maintenance Organization **AM** – Automobile Medical **BL** – Blue Cross/ Blue Shield **CH** - CHAMPUS	**CI** – Commercial Insurance Co **DS** – Disability **F1** – Federal Employees Program **HM** – Health Maintenance Organization **LM** – Liability Medical **MA** – Medicare Part A **MB** – Medicare Part B **OF** – Other Federal Program **TV** – Title V **VA** _ Veteran Administration Plan **WC** – Worker's Compensation Health Claim **ZZ** – Mutually Defined

Paid Date/Amount	Date other insurance payment was received, and amount of other insurance payment. This field is divided into two segments. In the left segment of the field, enter the 2-digit month, 2-digit day, and 4-digit year that the recipient's third party insurance carrier adjudicated the claim. For example, enter 10012015 if the date was October 1, 2015. Enter the amount paid by the other insurance carrier in the right segment of the field, using a decimal point. For example, enter 100.75 if the paid amount was $100.75.
Carrier Code (Policy Holder)	Third party insurance carrier. This field is automatically populated after you select a group number from the Group # field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Policy Holder List Form.*
Group # (Policy Holder)	Select the Group Number for the third party insurance from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.
Group Name (Policy Holder)	Name of the group or business that makes the insurance available to the insured person (this is not the third party insurance carrier). This field is automatically populated after you select a group number from the Group # field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Policy Holder List Form.*
Last Name (Policy Holder)	Policyholder's last name. This field is automatically populated after you select a group number from the Group # field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Policy Holder List Form.*
First Name (Policy Holder)	Policyholder's first name. This field is automatically populated after you select a group number from the Group # field. *Information cannot be entered directly into these fields; to add or change information in these fields, access the Policy Holder List Form.*
Remaining Patient Liability	In the judgment of the provider, this is the remaining amount to be paid after adjudication by the Other Payer

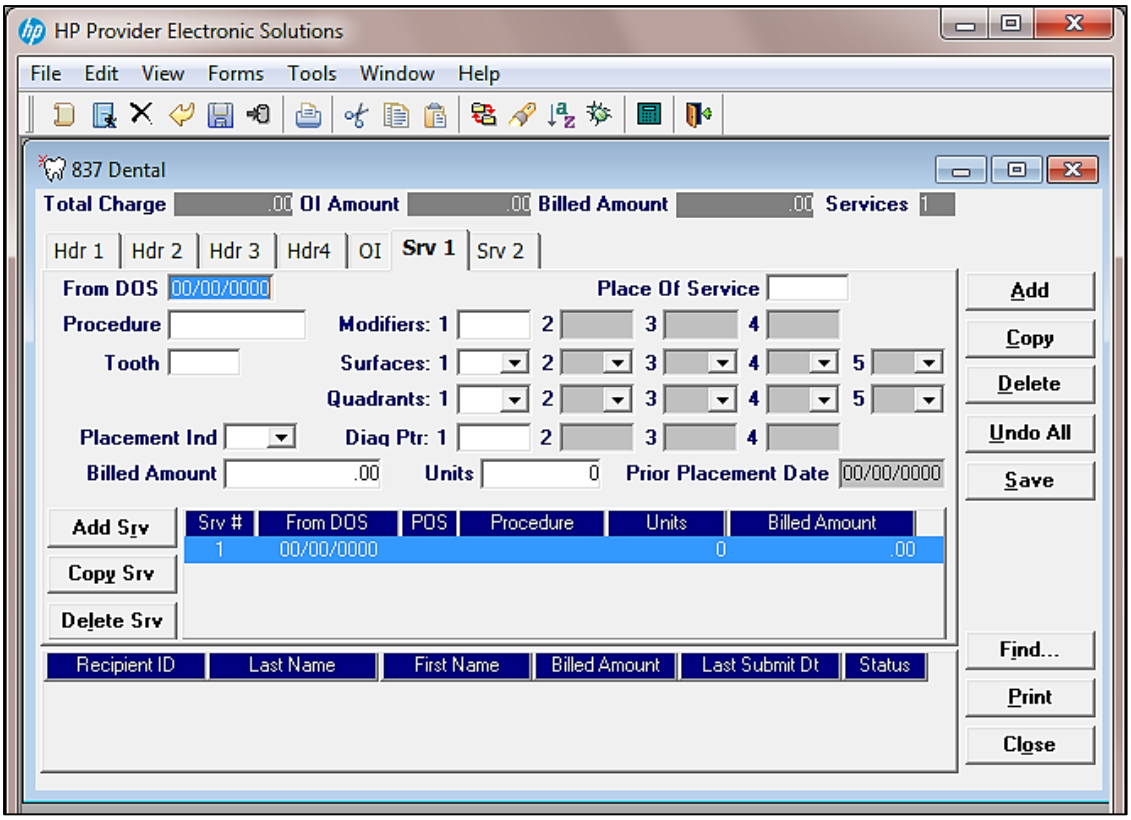
Non-Covered Amount	Required when the destination payer's cost avoidance policy allows providers to bypass claim submission to the otherwise prior payer
Insurance Type Code	The window is only active if the payer is Medicare with Claim filing code of MB and the Payer Responsibility is not P (Primary) Select the appropriate value from the dropdown box or enter an appropriate value as specified that identifies the type of insurance listed. **12** – Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan **13** –Medicare Secondary End-Stage Renal Disease in the Mandated Coordination Period with an Employer's Group Health Plan **14** – Medicare Secondary, No-fault Insurance including Auto is Primary **15** – Medicare Secondary, Worker's Compensation **16** – Medicare Secondary Public Health Service (PHS) or Other Federal Agency **41** – Medicare Secondary Black Lung **42** – Medicare Secondary Veteran's Administration **43** – Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) **47** – Medicare Secondary, Other Liability Insurance is Primary

Step 6.3 To add an additional other insurance line click Add OI. The software adds a new blank service line to the screen. Click on the new service line and then enter the other insurance data in the appropriate data fields.

Step 6.4 To copy data from an existing other insurance line to a new service line, click the existing service line that you want to copy and then click Copy OI. The software adds a new service line to the screen. The new service line has the same data as the existing service line that you previously selected. Edit the data in the new service line. Click the new service line and enter the changes in the appropriate fields.

Step 6.5 To delete an existing other insurance line, click on the service line that you want to delete and then click Delete OI. The selected service line is deleted.

Step 7. Complete Service Header 1.



Date Of Service	Enter the 2-digit month, 2-digit day, and 4-digit year that the services were rendered. For example, enter 10012015, if the date was October 1, 2015.
Place of Service	Select the place of service code from the drop down list or enter an appropriate value as specified. Place of service is the location where the service was performed. The only Place of Service codes accepted on an 837 Dental claim are: **03** – School **04** – Homeless Shelter **11** – Office, Outpatient Clinic, Independent Clinic **12** – Patient's Home or Community **15** – Mobile Unit **21** – Inpatient Hospital **22** – Outpatient Hospital **23** – Emergency Room – Hospital **24** - Ambulatory Surgical Center **25** - Birthing Center **26** – Military Treatment Center

	31 – Skilled Nursing Facility **32** – Nursing Facility **33** – Custodial Care Facility **34** – Hospice **35** – Adult Living Care Facility **41** – Ambulance - Land **42** – Ambulance – Air or Water **50** – Federally Qualified Health Center **51** – Inpatient Psychiatric Facility **52** – Psychiatric Facility Partial Hospitalization **53** – Community Mental Health Center **54** – Intermediate Care Facility/Mentally Retarded **55** – Residential Substance Abuse Treatment Facility **56** – Psychiatric Residential Treatment Center **60** – Mass Immunization Center **61** – Comprehensive Inpatient Rehabilitation Facility **62** – Comprehensive Outpatient Rehabilitation Facility **65** – End Stage Renal Disease Treatment Facility **71** – State or Local Public Health Clinic **72** – Rural Health Clinic **81** – Independent Laboratory **99** – Other Unlisted Facility If the place of service on Service Header 1 is different from the place of service on Claim Header 2, the place of service displayed on Service Header 1 is used in the adjudication process.
Procedure	Service that was rendered to the recipient. Enter the procedure code as listed in the MA Program Fee Schedule ***or*** Select the procedure code from the drop down list that was created ***or*** Enter the appropriate procedure code value as specified.
Modifiers	Enter the 2-digit modifier for the procedure code that was entered in the Procedure field. Only enter a modifier if the procedure code requires a modifier, as indicated by the MA Program Fee Schedule.
Tooth	Enter the 2-character code for the tooth on which the service was performed, in the range 00 to 32 for permanent teeth and A through T for primary teeth.

Surfaces, Fields 1-5	Each field identifies a tooth surface on which services were performed. Select the appropriate code from the drop down list or enter an appropriate value as specified, as described here:	
	B – Buccal **F** – Facial **L** – Lingual **O** –Occlusal	**D** – Distal **I** - Incisal **M** – Mesial
Quadrants, Fields 1-5	Each field identifies a mouth quadrant on which services were performed. Select the appropriate code from the fields' drop down lists or enter an appropriate value as specified:	
	00 – Entire Oral Cavity **01** – Maxillary Area **02** – Mandibular Area **09** – Other Area of Oral Cavity **10** – Upper Right Quadrant	**20** – Upper Left Quadrant **30** – Lower Left Quadrant **40** – Lower Right Quadrant **L** – Left **R** – Right
Placement Indicator	Select the placement code from the drop down list or enter an appropriate value as specified: Select **I —** Initial Placement - if the service requires an initial placement of a prosthetic. Select **R** — Replacement - if the service requires a replacement of an existing prosthetic.	
Diag Ptr	Enter the field number of the Diagnosis Codes field on the Header 2 Screen that contains the detail diagnosis number that references the diagnosis that relates to this service. This field will accept one numeric character. Valid values are one (1) through eight (8) to refer to the header diagnosis codes.	
Billed Amount	Enter the amount (using a decimal point) usually charged to the self-paying public for the service(s) provided. If billing for multiple units, multiply the usual charge by the number of units billed and enter that amount. Zero (0) billed amount is a permitted value.	
Units	Enter the number of units provided to the recipient for the service being billed. For example, enter 1, if one unit was provided to the recipient. Zero (0) units is a permitted value.	
Prior Placement Date	Enter the 2-digit month, 2-digit day, and 4-digit year the prosthetic being replaced was originally placed on the recipient. For example, enter 10012015 if the date was October 1, 2015.	

Step 7.1 To add another dental service line, click Add Srv.

A new blank service line is added to the screen.

Click on the new service line and then enter the dental service data in the data fields, as described previously.

Step 7.2 To copy the data from an existing dental service line to a new service line, click on the existing service line you want to copy and then click Copy Srv.

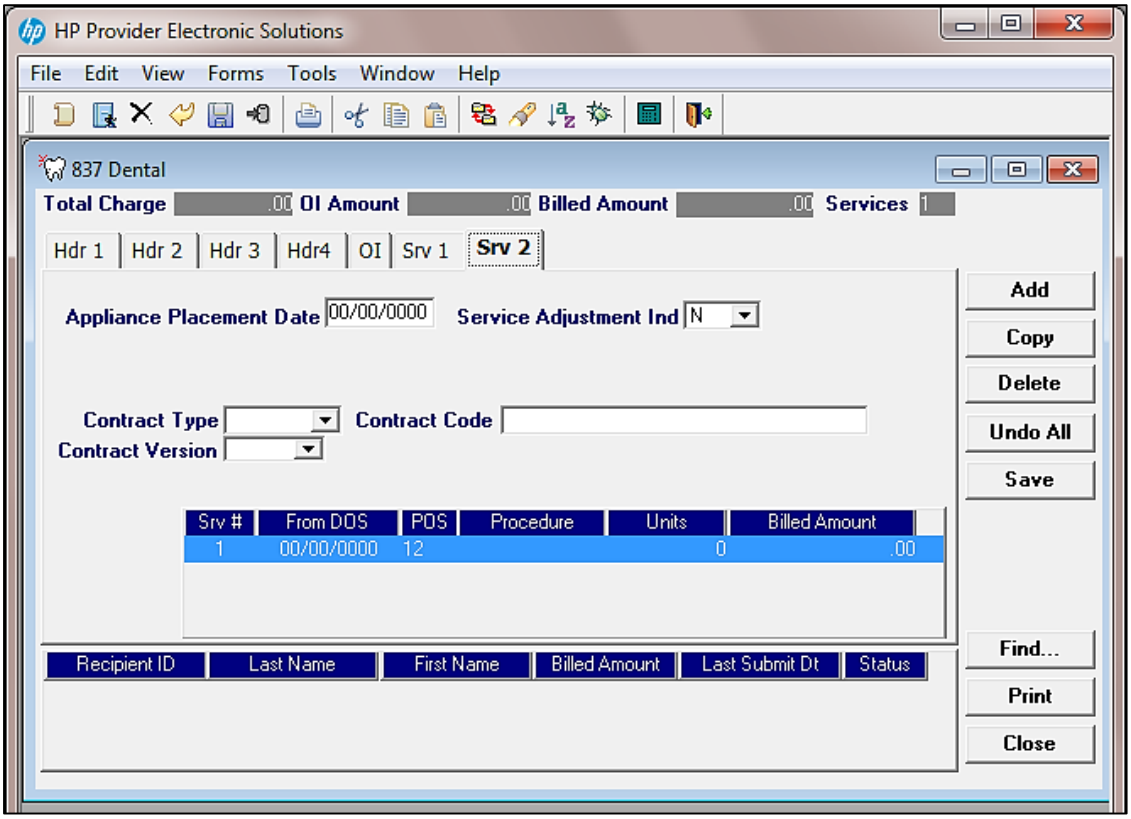
A new service line is added to the screen. The new service line has the same data as the existing service line that you previously selected.

You can edit the data in the new service line. Simply click on the new service line and enter the changes to the appropriate fields.

Step 7.3 To delete an existing dental service line, click on the service line you want to delete and then click Delete Srv.

The selected service line is deleted.

Step 8. Complete Service 2.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Dental
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr4 OI Srv 1 Srv 2
Appliance Placement Date 00/00/0000 Service Adjustment Ind N
Contract Type Contract Code
Contract Version
Srv # From DOS POS Procedure Units Billed Amount
1 00/00/0000 12 0 .00
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

If multiple dental service lines were entered on the Service 1 screen, these service lines also appear on the Service 2 screen. Each service line contains the data fields described in this step.

Step 8.1 Click on a service line to access its data fields.

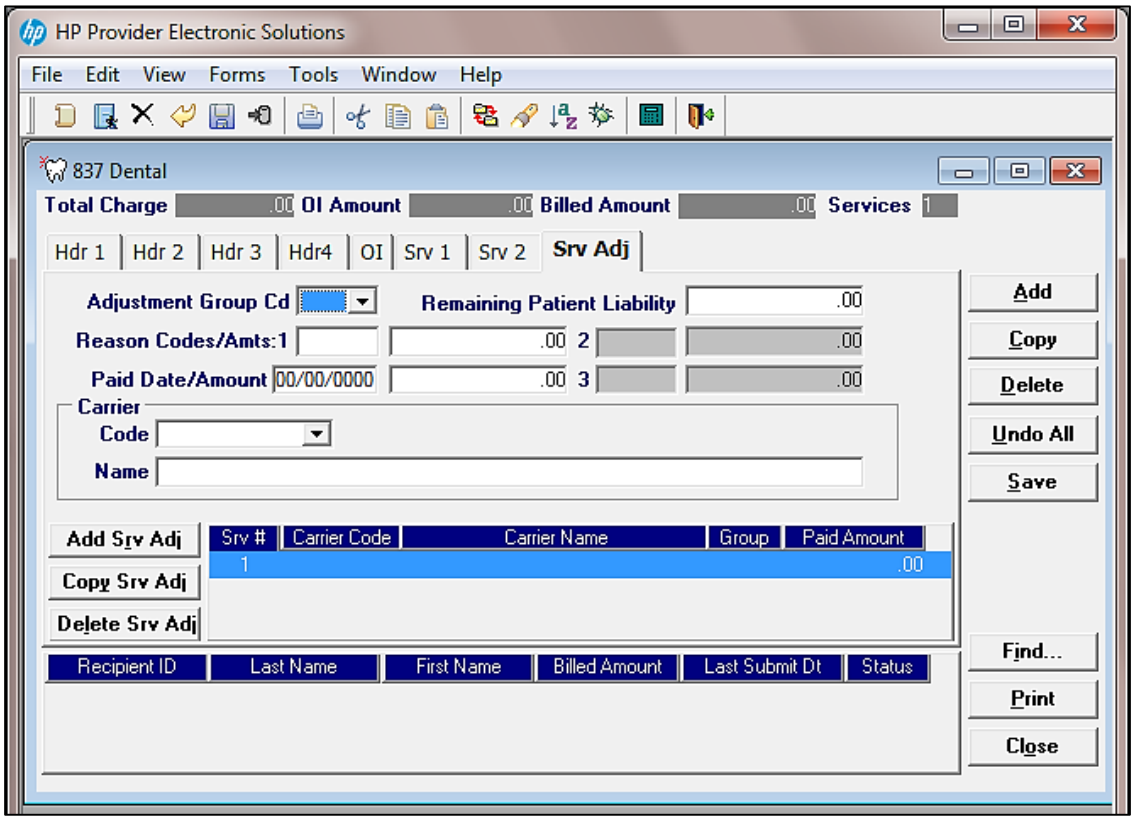
Appliance Placement Date	Enter the 2-digit month, 2-digit day, and 4-digit year the recipient received orthodontic appliances. For example, enter 10012015 if the date was October 1, 2015.
Service Adjustment Indicator	Select the adjustment code from the drop down list or enter an appropriate value as specified. Select **Y** if a third party insurance carrier has made a payment towards the claim. Selecting **Y** will add the Service Adjustment screen to the form for this claim line. Select **N** if a third party insurance carrier has not made a payment towards the claim.
Contract Type	The indicator represents the contract between the provider and the managed care or sub-capitation subcontractor. Choose a value from the drop-down list. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Code	The contract number between the provider and the managed care or sub-capitation subcontractor. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Version	If submitting a managed care claim where there is a sub-capitation arrangement, choose the contract version from the pull-down list. The contract version is the month of the contract that was in force at the time of the service. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).

Note: This is an adjustment made to the billed amount by an insurance carrier other than MA. For example, a service adjustment would be completed if a third party insurance carrier paid a monetary amount towards the claim, or denied the claim, prior to the claim being submitted to MA.

Note: Each service line is linked to a separate Service Adjustment screen. Therefore, it is necessary to complete the Service Adjustment screen for each service line that has received partial payment from a third party insurance carrier.

The Service Adjustment screen is added to the claim if you selected **Y** in the Service Adjustment Indicator field on the Service 2 screen. Access the Service Adjustment screen by clicking the Service Adj tab. The software displays the Service Adjustment screen, as shown below.

Step 9. Complete Service Adjustment.



Adjustment Group Cd	Identifies the general category of the adjustment made to the claim line. Select the adjustment group code from the drop down list or enter an appropriate value as specified, as described below:	
	CO – Contractual Obligations **CR** – Correction and Reversals **OA** – Other Adjustments	**PI** – Payer Initiated Reductions **PR** – Patient Responsibility – **Do not** Enter Patient Pay or Co-pay in the PR field.
Remaining Patient Liability	In the judgment of the provider, this is the remaining amount to be paid after adjudication by the Other Payer	

<table>
<tr><td rowspan="3">Reason Codes/Amts</td><td colspan="2">There are three Reason Code/Amount fields. Each field is divided into two segments.

In the left segment of the field, select the appropriate reason code from the segment’s drop down list or enter an appropriate value as specified. The reason code identifies the reason the adjustment is being made to the claim line, as described below:</td></tr>
<tr><td>1 – Deductible Amount
118 – ESRD Network Support adjustment
119 – Benefit Maximum for this time period has been reached
2 – Coinsurance Amount
23 – Payment adjusted because charges were paid by another payer
3 – Copayment Amount</td><td>35 – Lifetime Benefits Maximum has been reached, Including Medicare.
45 - Charge exceeds fee schedule/maximum allowable
50 – Non covered services</td></tr>
<tr><td colspan="2">Enter the amount of the adjustment in the right segment of the field, using a decimal point. For example, enter 100.75 if the adjustment amount was $100.75.</td></tr>
<tr><td>Paid Date/Amount</td><td colspan="2">This field is divided into two segments.

In the left segment of the field, enter the 2-digit month, 2-digit day, and 4-digit year that the recipient’s third party insurance carrier adjudicated the claim. For example, enter 10012015 if the date was October 1, 2015.

Enter the amount paid by the other insurance carrier in the right segment of the field, using a decimal point. For example, enter 100.75 if the paid amount was $100.75.</td></tr>
<tr><td>Code (Carrier)</td><td colspan="2">Select the carrier code from the drop down list or enter an appropriate value as specified. This field identifies the recipient’s third party insurance carrier. This code must match the carrier code selected on the Other Insurance screen. The list consists of the National Electronic Insurance Clearinghouse (NEIC) codes for insurance carrier.

Note: If the third party insurance carrier paid $0.00, complete the Paid Date/Amount field with the date of the third party insurance explanation of benefits (EOB) denial and the amount of $0.00.</td></tr>
</table>

Name	Name of the recipient's third party insurance carrier. This field is automatically populated after you select a carrier code in the Code field.

Step 9.1 To add another claim adjustment line, click Add Srv Adj. A new blank claim line is added to the screen. Click on the new claim line and then enter the claim adjustment data in the appropriate data fields, as described previously.

Step 9.2 To copy the data from an existing claim adjustment line to a new claim line, click on the existing claim line you want to copy and then click Copy Srv Adj. A new claim line is added to the screen. The new claim line has the same data as the existing claim line that you previously selected. Edit the data in the new claim line. Simply click on the new claim line and enter the changes in the appropriate fields.

Step 10. To delete an existing claim adjustment line, click on the claim line that you want to delete and then click Delete Srv Adj. The selected claim line is deleted from the screen.

Step 11. Click Save to save the dental claim.

Step 12. Click Add to start another dental claim

or

Click Close to exit the 837 Dental Form.

The claim adjustment lines are linked to the claim line that is highlighted when you access the Service Adjustment screen. Make sure that you have the correct service line highlighted for the adjustment you are entering.

9.5 Complete the 837 Institutional Inpatient Form

The 837 Institutional Inpatient form is used to create claims for inpatient services normally billed on a UB-04 paper claim form. The 837 Institutional Inpatient form is divided into seven screens.

Note: Consolidated Community Reporting for OMHSAS (CCR) submissions can now be performed starting with PES software Version 3.57.

Each screen contains the following claim data:

Hdr 1	Accesses the screen that contains the provider and recipient information.
Hdr 2	Access the screen that contains all diagnosis for ICD-9-CM/ICD-10-CM/PCS.
Hdr 3	Accesses the screen that contains any occurrence, condition, and coverage information.
Hdr 4	Accesses the screen that contains any value code

Hdr 5	Accesses the screen that contains admission, discharge, contract, and DRG information. **Note:** This screen has been revised with PES 3.57 for Consolidated Community Reporting for OMHSAS (CCR) submissions.
Hdr 6	Accesses the screen that contains Surgical code and date information. Enter the date the 2-digit month, 2-digit day and 4-digit year the procedure was performed in the right segment of the field. For example, enter 10012015 if the date was October 1st, 2015.
Hdr 7	Accesses the screen that contains Diagnosis Codes/Present on Admission, E Code and Auto Accident State.
Hdr 8	Accesses the screen that contains the Rendering Provider, Attending Provider and Operating Provider information.
Pat	Accesses the screen that contains patient information, which is used for newborns, and is accessed by selecting **Y** in the Newborn Indicator located under the Hdr 5 tab.
O/I	The O/I screen contains other insurance carrier information and is accessed by selecting "**Y**" in the Other Insurance Ind field, located under the Hdr 5 tab. **Note:** Consolidated Community Reporting (CCR) for OMHSAS submissions must include the MCO ICN when the Claim Filing Indicator Code field is "HM".
Crossover	The Crossover screen contains Medicare information. It is accessed by selecting **Y** in the Crossover Ind field, located under the Header 5.
Srv 1	This screen contains billing information.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

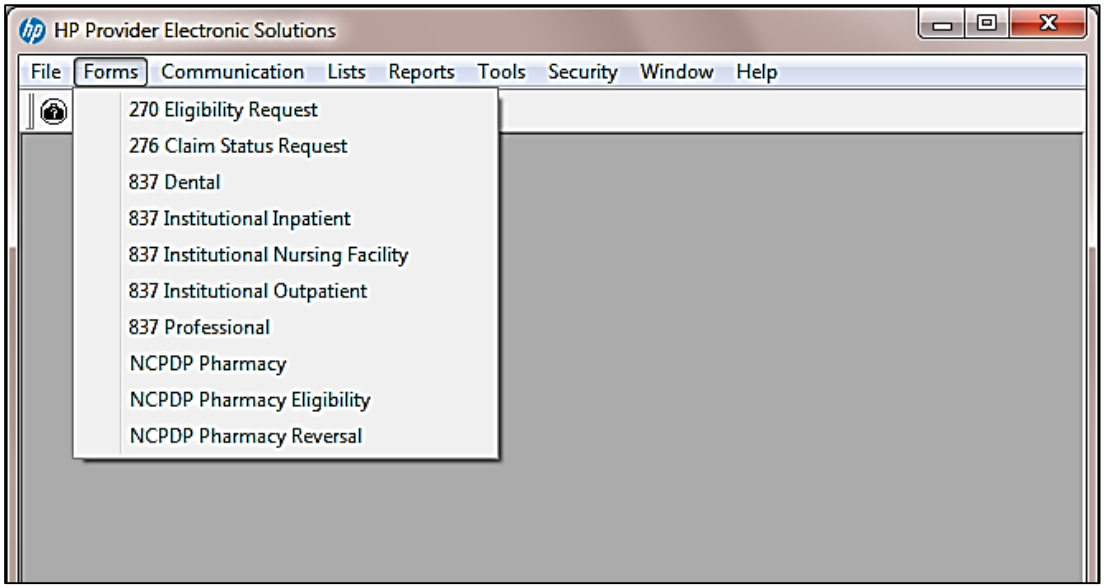
To complete an 837 Institutional Inpatient Claim, use the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software access the 837 Institutional Inpatient form one of two ways:

Click (837 Institutional Inpatient Shortcut icon) on the Toolbar

or

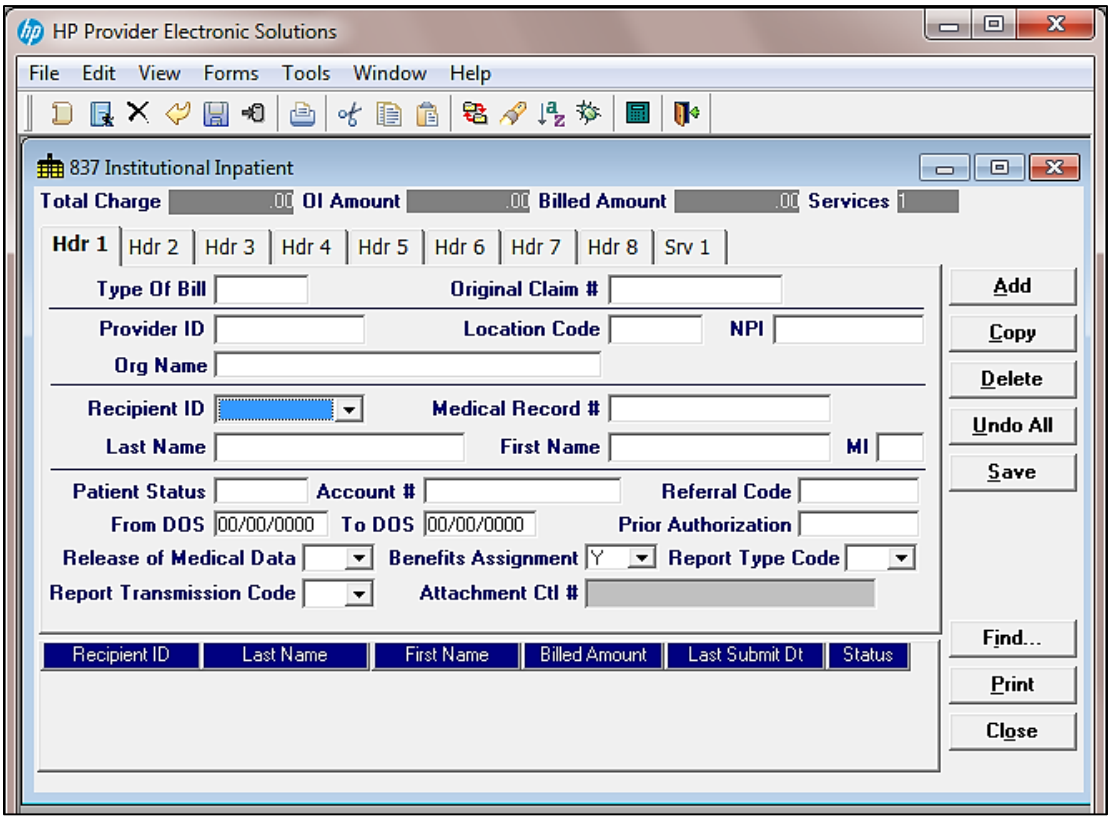
Select the 837 Institutional Inpatient form from the Forms drop down menu.



Note: When you choose a selection from a drop down list, (as indicated in the field completion instructions below) many of the fields are then completed. A drop down list is also known as a reference list. For additional information on reference lists, refer to the List options under Section 6.

Step 2. Complete Header 1.

The 837 Institutional Inpatient form is displayed with the Header 1 screen displayed:



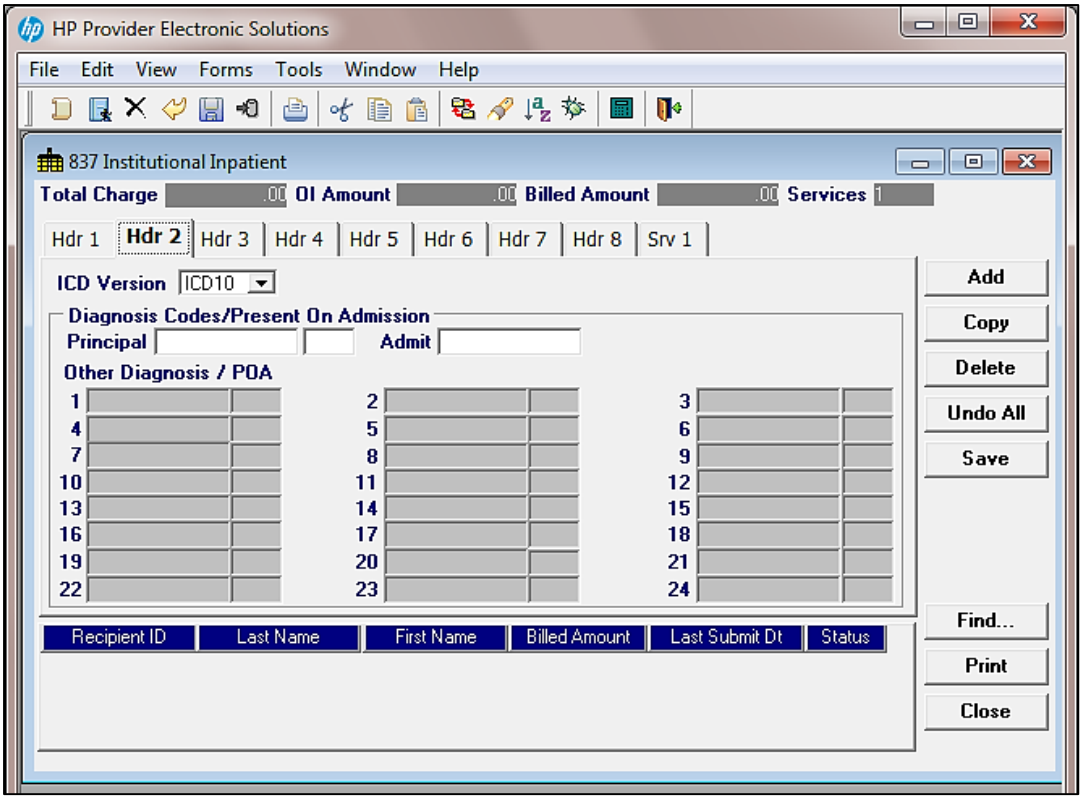
<table>
<tr><td>Type Of Bill</td><td>Enter the code that describes the type of bill submitted. Select the appropriate type of bill code from the drop down list, or enter an appropriate value as specified:<table><tr><th>Form Name</th><th>Type of Bill Codes</th></tr><tr><td>837 Institutional Inpatient</td><td>110 –Inpatient – Zero/No Pay Claim
111 – Inpatient - Admit Through Discharge Claim
112 – Inpatient - Interim – First Claim
117 – Inpatient - Replacement of Prior Claim
118 – Inpatient - Void/Cancel of Prior Claim
Note: Types of Bills 113 and 114 and not valid values for PA MA.</td></tr></table></td></tr>
<tr><td>Original Claim #</td><td>Enter the original ICN by following the guidelines below:
When using Type of Bill 111 to resubmit a previously rejected claim, enter the 13-digit ICN as printed on the RA statement.
When using Type of Bill 117 or 118 to adjust or void a previously paid claim, enter the 13-digit ICN as printed on the RA statement.
If submitting a claim adjustment for a claim processed prior to the implementation of PROMISe™ or when resubmitting a previously rejected claim processed prior to the implementation of PROMISe™, enter the 10-digit CRN followed by the 2-digit line number as printed on the RA statement.</td></tr>
<tr><td>Provider ID</td><td>Select the 9-digit MPI number for the provider that the claim will be paid under (billing provider) from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.</td></tr>
<tr><td>Location Code</td><td>4-digit location code associated with the MPI number selected in the Provider ID field. This field is automatically populated after you select or enter an MPI number in the Provider ID field.
Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.</td></tr>
<tr><td>NPI</td><td>Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.</td></tr>
<tr><td>Org Name</td><td>Provider’s last name or the name of the group or facility. This field is automatically populated after you select or enter an MPI number in the Provider ID field.</td></tr>
</table>

	Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider	
Recipient ID	Select the recipient's 10-digit recipient number. For additional information on the Recipient ID field, refer to the "Complete a Recipient reference list," heading, found in Section 8 of the *Provider Electronic Solutions Software User's Guide.* *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*	
Medical Record Number	Your own reference number for the recipient. This field is automatically populated after you select or enter a Recipient number. This data appears in the first column of the RA statement when the claim is adjudicated. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*	
Last Name	Recipient's last name. This field is automatically populated after you select or enter a Recipient number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*	
First Name	Recipient's first name. This field is automatically populated after you select or enter a Recipient number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*	
MI	Recipient's middle initial. This field is automatically populated after you select or enter a recipient number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*	
Patient Status	Recipient's status on the last date of service billed on this claim. Enter the appropriate 2-digit status code or select the status code from the drop down list or enter an appropriate value as specified:	
	01 – Dischrgd to home or self-care (routine discharge) **02** – Dischrgd/trnsfrrd to another hospital for inpatient care **03** – Dischrgd/transfrrd to skilled nursing facility **04** – Dischrgd/transfrrd to an intermediate care facility	**05** – Dischrgd/transfrrd to another type of institution for inpatient care **07** – Left against medical advice or discontinued care **20** – Expired **30** – Still a patient

Account Number	Enter the medical record number, assigned to the recipient by the provider, for the service that was performed. A unique account number is required for each claim submitted to be able to obtain claim status information. If the same account number is used for each claim submitted, the claim status is reported on **all** claims with that account number when a claim status request is sent.
Referral Code	The status code indicates the **PCCM Referral number** – If there is a referral from a Primary Care Case Manager (PCCM), enter the referral number into this field. Not currently used.
From DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient first received service under this claim. For example, enter 10012015 if the date was October 1, 2015. If the same service was provided on a single day, enter the date of service in both the From DOS and To DOS fields.
To DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient last received service under this claim. For example, enter 10012015 if the date was October 1, 2015.
Prior Authorization	Enter the 10-digit CHR/DRG/PSR admission certification number. Enter the 10-digit Prior Authorization number if the service requires and has received prior authorization. Enter the 10-digit PSR number if the admission is elective to an acute care hospital, a hospital short procedure unit (SPU), or an ambulatory surgical center (ASC). Enter the 10-digit admission certification number for urgent or emergency admission to an acute care hospital, a SPU, an ASC, or specialty hospital.
Release of Medical Data	Select the appropriate release code from the drop down list, or enter an appropriate value as specified: Select **I** – Informed Consent to Release Medical Information - for conditions or diagnosis regulated by federal statutes. Select **Y** – Yes, Provider has a Signed Statement Permitting Release of Medical Billing \Data Related to a Claim.
Benefits Assignment	Select the appropriate assignment code from the drop down list, or enter an appropriate value as specified: Select **Y** if the recipient, or authorized person, has authorized benefits to be assigned to the provider.

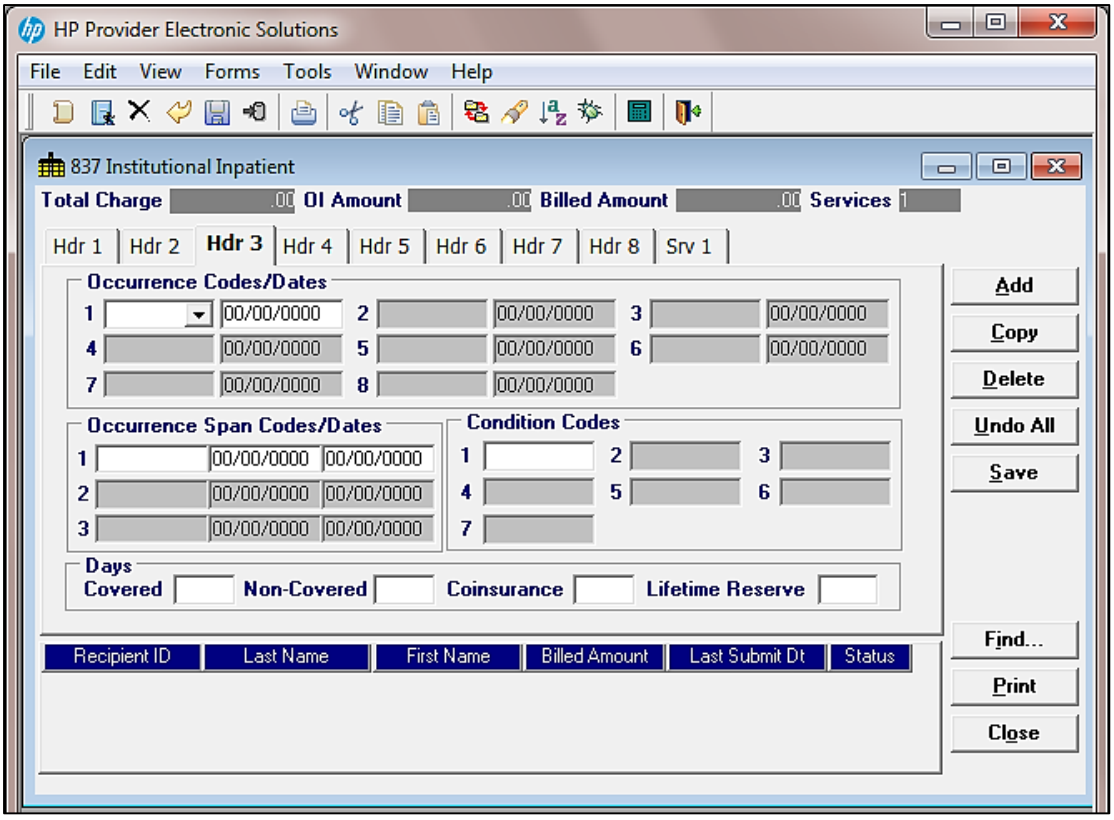
<table>
<tr><td></td><td colspan="2">Select N if the recipient, or authorized person, has not authorized benefits to be assigned to the provider.
Select W for Not Applicable – Not applicable for this claim.</td></tr>
<tr><td rowspan="2">Report Type Code</td><td colspan="2">Enter the appropriate code for the type of attachment submitted from the drop down list or enter an appropriate value as specified :</td></tr>
<tr><td>AS – Admission Summary
B2 – Prescription
B3 – Physician Order
B4 – Referral Form
CT – Certification
DA – Dental Models
DG – Diagnostic Report
DS – Discharge Summary
EB – Explanation of Benefits
MT – Models</td><td>NN – Nursing Notes
OB – Operative Notes
OZ – Support Data for Claim
PN – Physical Therapy Notes
PO – Prosthetics or Orthotic Certification
PZ – Physical Therapy Certification
RB – Radiology Films
RR - Radiology Reports
RT – Report of Tests and Analysis Report</td></tr>
<tr><td>Report Transmission Code</td><td colspan="2">Enter the appropriate code for the method of attachment transmission.
AA – Available by request at Provider site
BM – By Mail
EL – Electronically Only
EM – E-mail
FT – File Transfer
FX – By Fax</td></tr>
<tr><td>Attachment Control Number</td><td colspan="2">Enter the 10-digit ACN obtained from the PROMISe™ web site. This number is used when a paper attachment is required by MA to cross-reference the paper attachment with the electronic claim. This number must also be written on the cover letter sent to MA.</td></tr>
</table>

Step 3. Complete Header 2.



ICD Version	Use the ICD 9/ICD10 Version for the code being submitted.
Principal (Diagnosis Codes)	Principal (primary) diagnosis code is the most specific ICD-9-CM/ICD-10-CM/PCS diagnosis code that relates to a recipient's stay. Select the principal diagnosis code from the drop down list, or enter an appropriate value as specified.
Other, Fields 1-24 (Diagnosis Codes)	Each of these fields can identify an additional diagnosis code for the form. Select the additional diagnosis code(s) from the drop down list, or enter an appropriate value as specified.
Admit (Diagnosis Codes)	ICD-9-CM/ICD-10-CM/PCS diagnosis code corresponding to the diagnosis that prompted the recipient's admission to the hospital. Select the admission diagnosis code from the drop down list, or enter an appropriate value as specified.

Step 4. Complete Header 3.

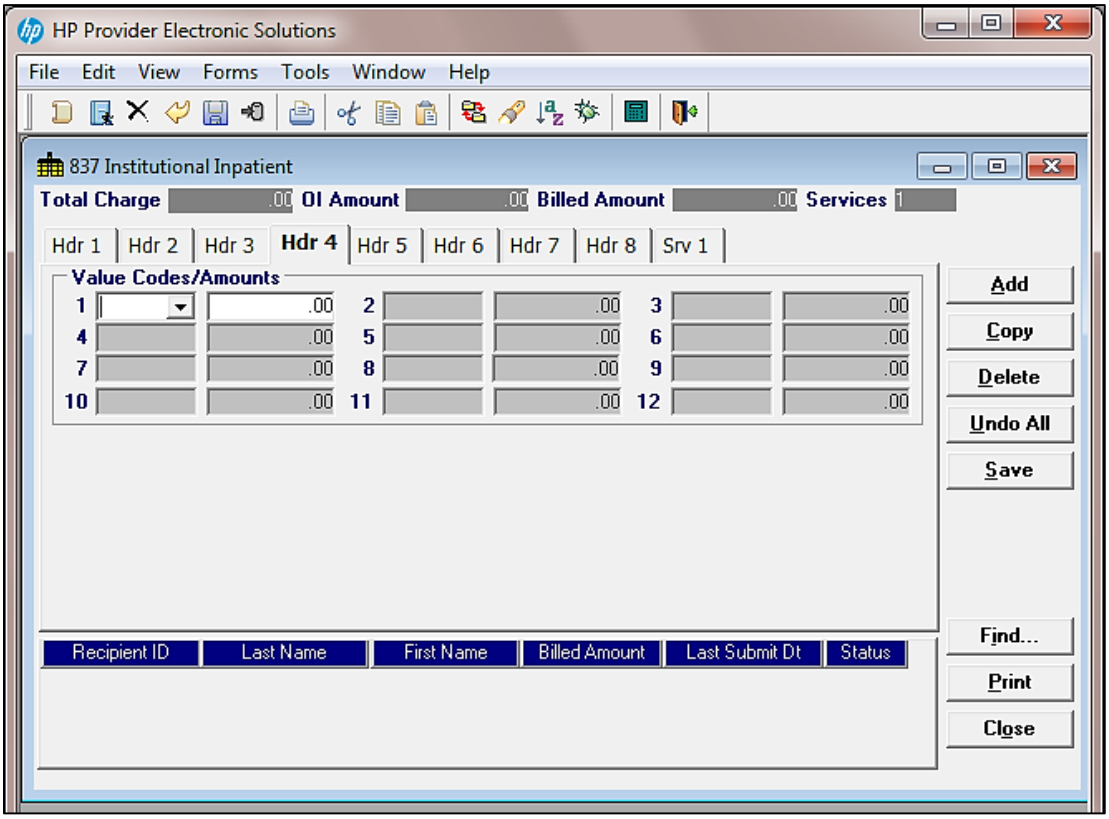


Occurrence Codes/Dates, Fields 1-8	Each field is divided into two segments. In the left segment of the field, enter an appropriate occurrence code as specified, or select the appropriate occurrence code from the segment's drop down list, as described below.	
	01 – Auto Accident **02** – No Fault Insurance Involved-Including Auto Accident/Other **03** – Accident/Tort Liability **04** – Accident/Employment Related **05** – Other Accident **06** – Crime Victim	**24** – Date Insurance Denied **25** – Date Benefits Terminated By Primary Payer **71** – Prior Stay Dates **74** – Noncovered Level of Care/Leave of Absence **DR** – Disaster Related **MR** – Disaster Related
	In the right segment of the field, enter the 2-digit month, 2-digit day, and 4-digit year associated with occurrence code in the right segment of the field.	
	Each field is divided into three segments.	

<table>
<tr><td rowspan="3">Occurrence Span Codes/Dates, Fields 1-3</td><td colspan="2">In the left segment of the field, enter the appropriate occurrence span code as specified or select the appropriate occurrence span code from the segment’s drop down list, as described below:</td></tr>
<tr><td>01 – Auto Accident
02 – No Fault Insurance Involved-Including Auto Accident/Other
03 – Accident/Tort Liability
04 – Accident/Employment Related
05 – Other Accident
06 – Crime Victim</td><td>24 – Date Insurance Denied
25 – Date Benefits Terminated By Primary Payer
71 – Prior Stay Dates
74 – Noncovered Level of Care/Leave of Absence
DR – Disaster Related
MR – Disaster Related</td></tr>
<tr><td colspan="2">In the middle segment, enter the 2-digit month, 2-digit day and 4-digit year the period of hospitalization began.
In the right segment, enter the 2-digit month, 2-digit day, and 4-digit year the period of hospitalization ended.</td></tr>
<tr><td>Condition Codes, Fields 1 – 7</td><td colspan="2">Each field identifies a condition relating to the invoice that may affect payer processing. Enter the appropriate 2-character condition code, or select the appropriate code from the drop down list, or enter an appropriate value as specified:
02 – Condition is Employment Related
03 – Patient Covered by Insurance Not Reflected Here
05 – Lien Has Been Filed
60 – Day Outlier
77 – Payment was accepted payment in full
A1 – EPSDT/CHAP
A3 - Special Federal Funding
A4 – Family Planning
A7 – Induced Abortion– Danger to Life
A8 – Induced Abortion – Victim Rape/Incest
AI – Sterilization
B3 – Pregnancy
DR – Disaster Related</td></tr>
<tr><td>Covered Days</td><td colspan="2">Enter the number of days covered by MA for the period of hospitalization.
The discharge day should not be counted as a covered day.</td></tr>
</table>

Non-Covered Days	Enter the number of days not covered by MA for the period of hospitalization. **The discharge day should not be counted as a non-covered day.**
Coinsurance	Enter the number of coinsurance days that apply to this period of hospitalization.
Lifetime Reserve	Enter the number of lifetime reserve days.

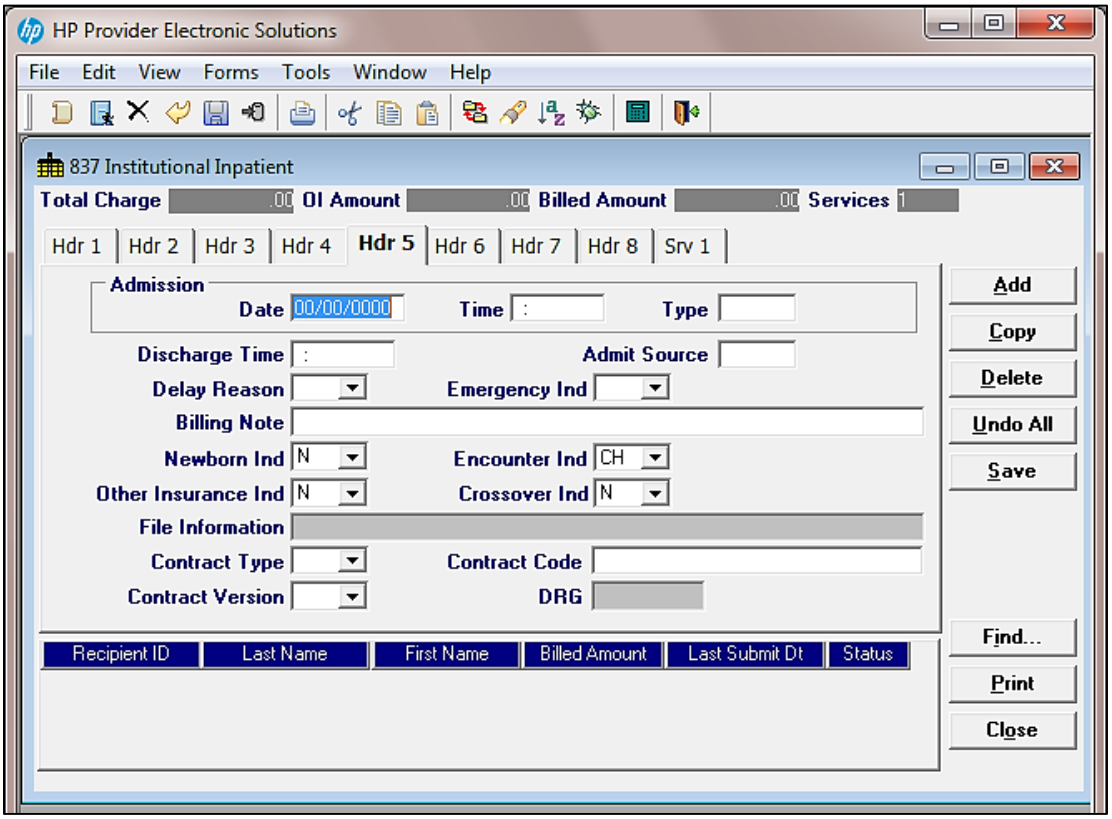
Step 5. Complete Header 4.



Value Codes/ Amounts Fields 1-12	Each field is divided into two segments. In the left segment of the field, enter the value code, or select the value code from the segment's drop down list or enter an appropriate value as specified. The value code identifies data of a monetary nature that is necessary for processing the form, as required by the payer organization.	
	06 – Medicare Blood Deductible **14** – No Fault Auto/Other **15** – Workman's Compensation	**35** – Offset to Patient Payment Amount – Health Insurance Premium

	16 – PHS or Other Federal Agency **25** – Drug Deduction **31** – Patient Liability Amount **34** – Offset to Patient Payment Amount – Other Medical Expense	**38** – Medicare Blood Deductible Pints Furnished **39** - Medicare Blood Deductible – Pints Replaced **47** – Any Liability Insurance **66** – Patient Paid Amount
	In the right segment of the field, enter the dollar amount for each code, using a decimal point.	

Step 6. Complete Header 5.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Inpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 Hdr 6 Hdr 7 Hdr 8 Srv 1
Admission
Date 00/00/0000 Time : Type
Discharge Time : Admit Source
Delay Reason Emergency Ind
Billing Note
Newborn Ind N Encounter Ind CH
Other Insurance Ind N Crossover Ind N
File Information
Contract Type Contract Code
Contract Version DRG
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

Date (Admission)	Enter the 2-digit month, 2-digit day, and 4-digit year the recipient was admitted to the facility. For example, enter 10012015 if the date was October 1, 2015.
Time (Admission)	Enter the hour during which the patient was admitted. Enter the hour in military (twenty-four-hour) time. For example: 12:00 – 12:59 – Midnight = **00:00** 12:00 – 12:59 – Noon = **12:00** 6:00 – 6:59pm - 6:00p.m. = **18:00**

Type (Admission)	Enter the code that identifies the type of admission to the facility as specified, or choose the appropriate code from the field's preloaded drop down list:	
	1 – Emergency Admission.	Patient's condition requires immediate medical attention and any time delay would be harmful to the patient.
	2 – Urgent Admission.	Patient's condition, while not immediately essential, should have medical attention provided very early to prevent possible loss or impairment of life, limb, or bodily function.
	3 – Elective Admission.	Scheduled or planned admission.
	4 – Newborn	Admission of a newborn baby.
	5 – Trauma Center	Admission to a trauma center.
Discharge Time	Enter the hour during which the patient was discharged. Enter the hour in military (twenty-four-hour) time. For example: 12:00 – 12:59 – Midnight = **00:00** 12:00 – 12:59 – Noon = **12:00** 6:00 – 6:59 - 6:00p.m. = **18:00**	
Admit Source	Enter the code that identifies the source of admission to the facility as specified, or choose the appropriate code from the field's preloaded drop down list as described below: **1** – Physician Referral **2** – Clinic Referral **3** – HMO Referral **4** – Transfer from a Hospital **5** – Transfer from a Skilled Nursing Facility **6** – Transfer from Another **7** – Emergency Room **8** – Court/Law **9** – Information Not Available **A** – Transfer from a Rural Primary Care Hospital	
Delay Reason	Enter the appropriate code to indicate why a claim is being submitted outside of the 180-day initial submission window. This is an optional field.	
	1– Proof of Eligibility Unknown or Unavailable **2** – Litigation **3** – Authorization Delays	**8** – Delay in Eligibility Determination **9** – Original Claim Rejected or Denied due to a Reason Unrelated to the Billing Limitation Rules

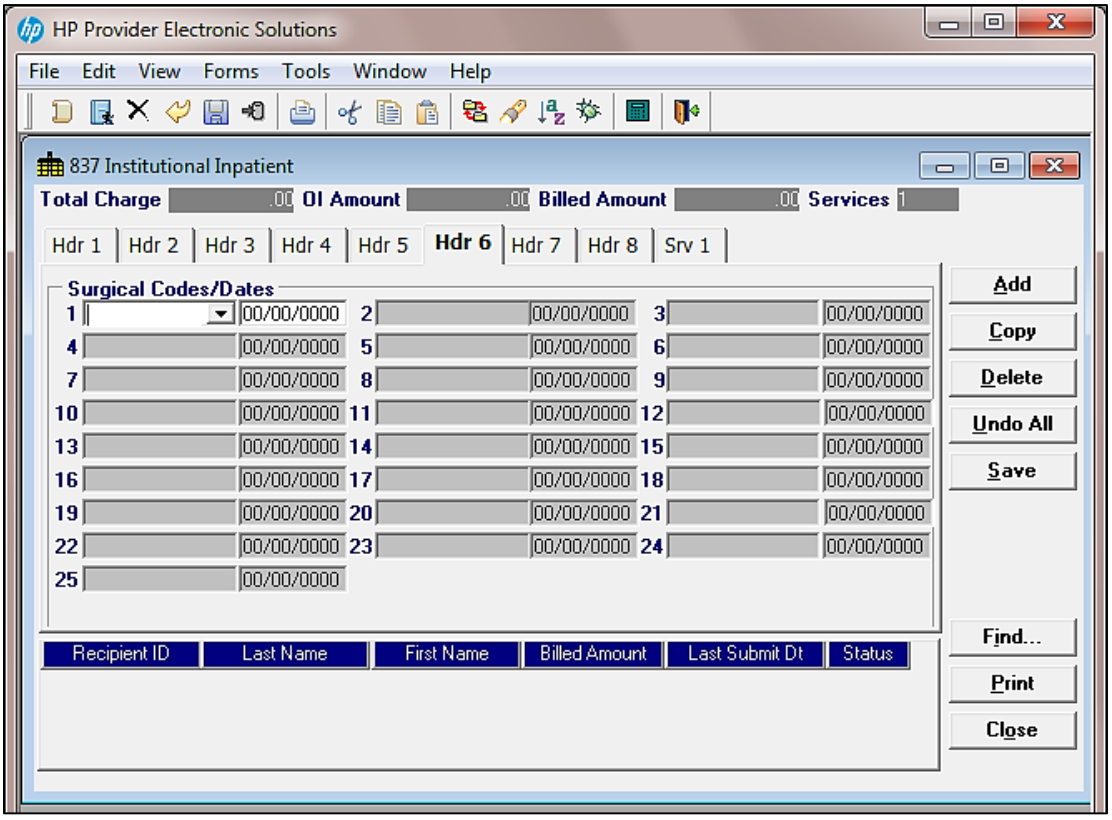
<table>
<tr><td></td><td>4 – Delay in Certifying Provider
5 – Delay in Supplying Billing Forms
6 – Delay in Delivery of Custom Made Appliances
7 – Third Party Processing Delay</td><td>10 – Administration Delay in the Prior Authorization Process
11 - Other</td></tr>
<tr><td>Emergency Indicator</td><td colspan="2">Select the appropriate Emergency Indicator code from the drop down list or enter an appropriate value as specified.
Select 3, if the service provided was in response to an emergency.</td></tr>
<tr><td>Billing Note</td><td colspan="2">This field pertains to information related to visit codes, and additional information required to adjudicate MA claims. Enter the following codes if they apply: (Multiple codes should be entered in one string, for example: VC09QSB)
<table>
<tr><th>If the visit code is…</th><th>This means…</th><th>Then Enter…</th></tr>
<tr><td>09</td><td>Services rendered to a pregnant woman (Dental only)</td><td>VC09</td></tr>
<tr><td>10</td><td>Services rendered to an LTC or a state mental hospital resident</td><td>VC10</td></tr>
<tr><td>11</td><td>Provider attempted but was unsuccessful in collecting a co-payment</td><td>VC11</td></tr>
<tr><td>QSB</td><td>If the provider is a Qualified Small Business</td><td>QSB</td></tr>
<tr><td>EPSDT</td><td colspan="2">If the claim involved EPSDT referral information, any of the following that apply must be entered:</td></tr>
<tr><td></td><td>EPSDT – Dental Referral</td><td>YD</td></tr>
<tr><td></td><td>EPSDT – Vision Referral</td><td>YV</td></tr>
</table></td></tr>
</table>

			EPSDT – Hearing Referral	**YH**	
			EPSDT – Medical Referral	**YM**	
			EPSDT – Behavioral Health Referral	**YB**	
			EPSDT – Other Referral	**YO**	

	If the provider is a qualified small business, enter QSB in the Billing Note field. You may enter more than one code, if applicable. Example: VC09QSB for a claim filed by a qualified small business dental provider for services rendered to a pregnant woman.
Newborn Indicator	Select the newborn indicator code from the drop down list, or enter the appropriate value, as described below or enter an appropriate value as specified: Select **Y** —Yes- if the recipient is a newborn. Select **N** — No-if the recipient is not a newborn.
Encounter Ind	Select the encounter indicator from the field's pull down list. o Select RP, if the claim is an encounter record (Consolidated Community Reporting Use Only) o Select CH, if the claim is a Fee for Service claim. The default value for this field is CH.
Other Insurance Indicator	Select the other insurance code from the drop down list, or enter an appropriate value as specified, as described below: Select **Y —** Yes-if the recipient has other insurance. Select **N —** No-if the recipient does not have other insurance.
Crossover Indicator	The Crossover Indicator is used to determine the recipient's Medicare information. Select the crossover code from the drop down list, or enter an appropriate value as specified, as described below: Select **Y —** Yes-if the recipient has Medicare coverage. Select **N —** No-if the recipient does not have Medicare coverage.
File Information	Must start with POA, must end with Z. Only characters allowed are Y, N, U, W, 1. Total count of characters between "POA" and "Z" must be equal to the primary diagnosis code plus the number of other diagnosis codes.

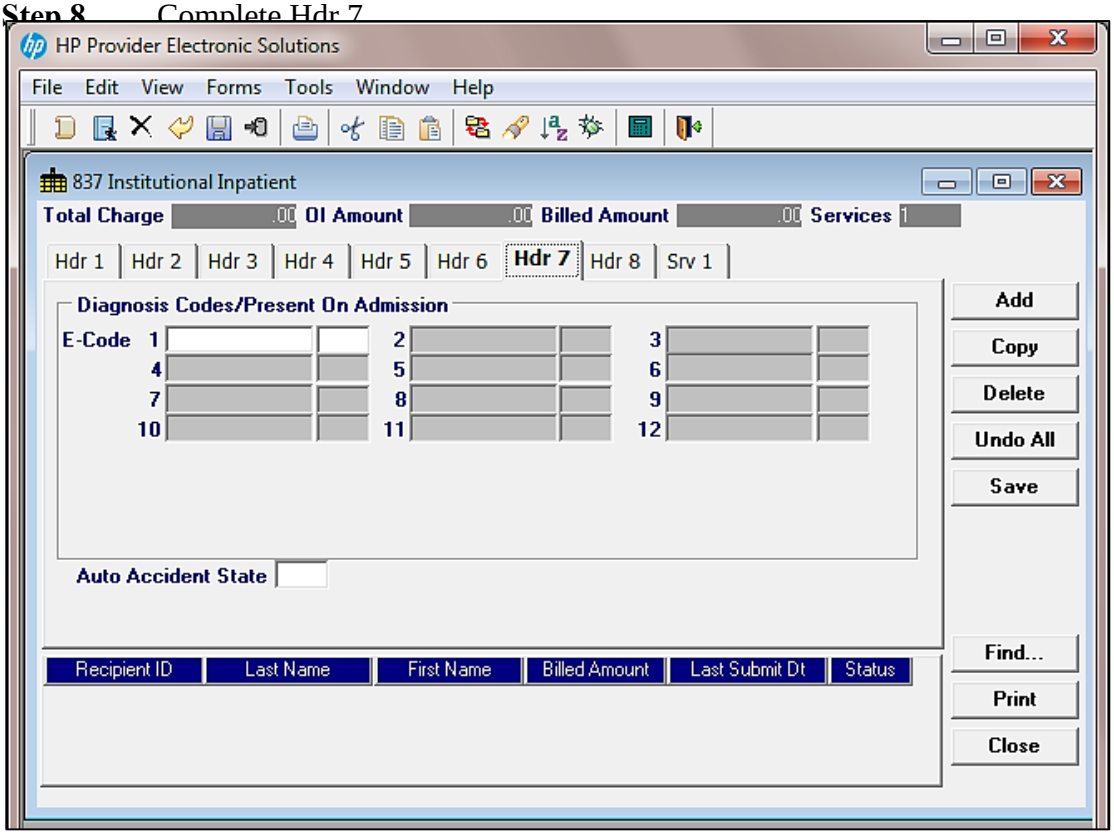
Contract Type	The indicator represents the contract between the provider and the managed care or sub-capitation subcontractor. Choose a value from the drop-down list. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Code	The contract number between the provider and the managed care or sub-capitation subcontractor. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Version	If submitting a managed care claim where there is a sub-capitation arrangement, choose the contract version from the pull-down list. The contract version is the month of the contract that was in force at the time of the service. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
DRG (Diagnosis Related Group)	DRG is the diagnosis related group under which inpatient claims are adjudicated. Information in this field is required for any inpatient encounter Consolidated Community Reporting for OMHSAS (CCR) submission. Enter the appropriate CCR DRG. **Note:** The DRG field is activated when "RP" is indicated on Hdr 5 AND has a payer on the OI tab with the Claim Filing Indicator Code "HM". Without both conditions being met, the DRG field will remain disabled.

Step 7. Complete Header 6


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Inpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 Hdr 6 Hdr 7 Hdr 8 Srv 1
Surgical Codes/Dates
1 00/00/0000 2 00/00/0000 3 00/00/0000
4 00/00/0000 5 00/00/0000 6 00/00/0000
7 00/00/0000 8 00/00/0000 9 00/00/0000
10 00/00/0000 11 00/00/0000 12 00/00/0000
13 00/00/0000 14 00/00/0000 15 00/00/0000
16 00/00/0000 17 00/00/0000 18 00/00/0000
19 00/00/0000 20 00/00/0000 21 00/00/0000
22 00/00/0000 23 00/00/0000 24 00/00/0000
25 00/00/0000
Recipient ID
Last Name
First Name
Billed Amount
Last Submit Dt
Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

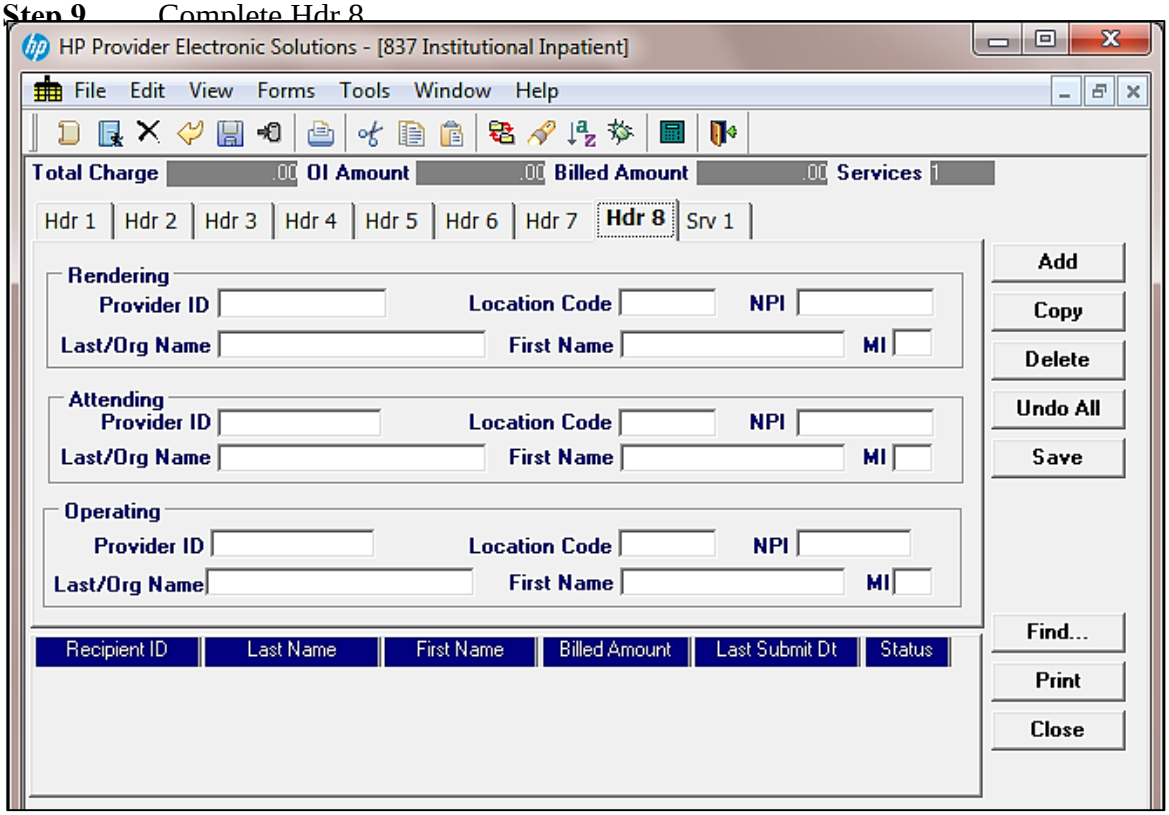
Surgical Codes/Dates **1-24**	Each field is divided into two segments. In the left segment of the field, enter the procedure code or select the procedure code from the field's pull down list, as indicated in the MA Program Fee Schedule. The procedure code identifies (I ICD-9-CM/ICD-10-CM/PCS for Inpatient or CPT for Outpatient) the procedure that was performed during the billing period as shown in the recipient's medical record. Enter the date the 2-digit month, 2-digit day and 4-digit year the procedure was performed in the right segment of the field. For example, enter 10012015 if the date was October 1st, 2015.

Step 8 Complete Hdr 7


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Inpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 Hdr 6 Hdr 7 Hdr 8 Srv 1
Diagnosis Codes/Present On Admission
E-Code 1 2 3
4 5 6
7 8 9
10 11 12
Auto Accident State
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

E-Code (Diagnosis Codes/Present on Admission)	This code represents the external cause of injury. Enter the external diagnosis code or select the external code from the field's pull down list or enter an appropriate value as specified. Required on Institutional claims whenever a diagnosis is needed to describe an injury, poisoning, or adverse effect. In the second part of this enter the value from the drop down or enter an appropriate value as specified. **N** – No **U** – Unknown **W** – Not Applicable **Y** - Yes
Auto Accident State (Diagnosis Codes/Present on Admission)	Enter the two-letter abbreviation for the state where the accident occurred. For example, enter **PA** for Pennsylvania.

Step 9 Complete Hdr 8

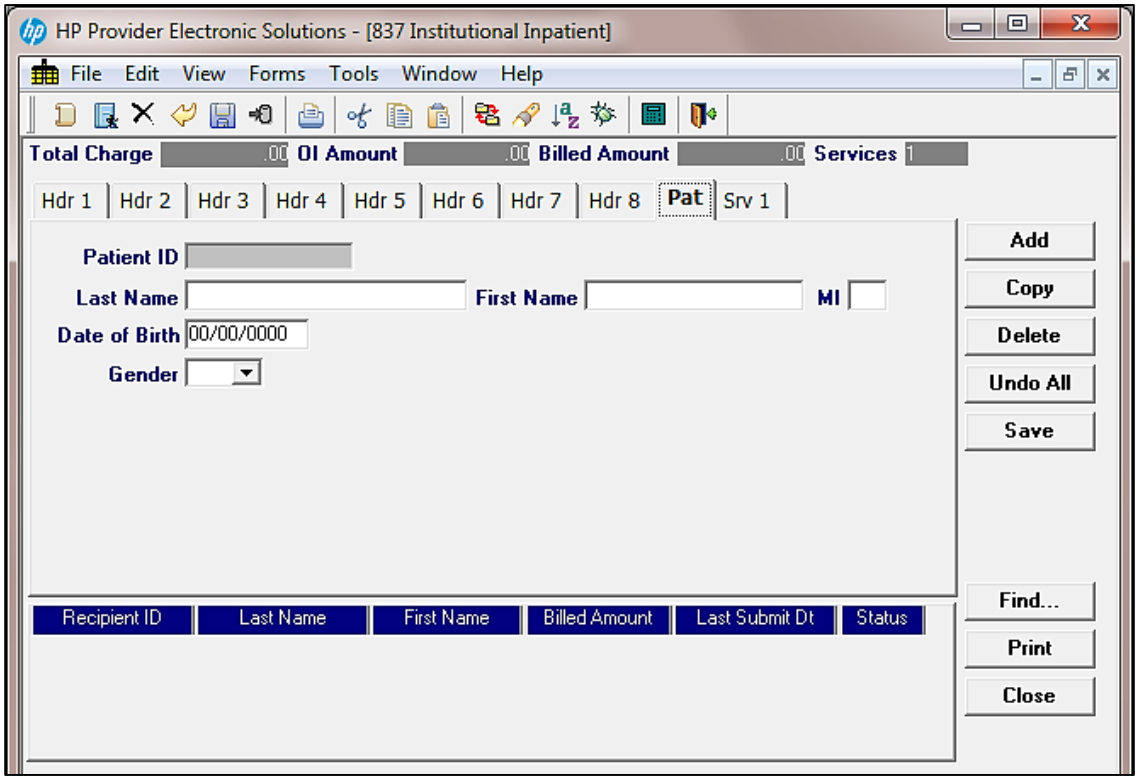

HP Provider Electronic Solutions - [837 Institutional Inpatient]
File Edit View Forms Tools Window Help
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 Hdr 6 Hdr 7 Hdr 8 Srv 1
Rendering
Provider ID Location Code NPI
Last/Org Name First Name MI
Attending
Provider ID Location Code NPI
Last/Org Name First Name MI
Operating
Provider ID Location Code NPI
Last/Org Name First Name MI
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

Provider ID (Rendering)	Select the 9-digit MPI number for the provider that the claim will be paid under (billing provider) from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.
Location Code (Rendering)	4-digit location code associated with the MPI number selected in the Provider ID field. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Rendering)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Rendering)	Provider's last name or the name of the group or facility. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Rendering)	Other provider's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Other) field. Information cannot be

	entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
MI (Rendering)	Other provider's middle initial. This field is automatically populated after you select or enter an MPI number in the Provider ID (Other) field. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
Provider ID (Attending)	Select the 8- or 9-character Medical License Number of the attending provider from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.
Location Code (Attending)	4-digit location code associated with the MPI number selected in the Provider ID field. This field is automatically populated after you select or enter an MPI number in the Provider ID (Attending) field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Attending)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Attending)	Attending provider's last name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Attending) field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Attending)	Attending provider's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Attending) field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
MI (Attending)	Attending provider's middle initial. This field is automatically populated after you select or enter an MPI number in the Provider ID (Attending) field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Provider ID (Operating)	Select the 8- or 9-character Medical License number for the operating or surgical physician from the drop down list or double-click on the data entry portion of the field to add a reference list selection.
Location Code (Operating)	4-digit location code associated with the MPI number selected in the Provider ID field. This field is automatically populated after you select or enter an MPI number in the Provider ID field.

	Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
NPI (Operating)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Operating)	Operating physician's last name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Operating) field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Operating)	Operating physician's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID (Operating) field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
MI (Operating)	Operating physician's middle initial. This field is automatically populated after you select or enter an MPI number in the Provider ID (Operating) field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*

Step 10. Complete PAT.


HP Provider Electronic Solutions - [837 Institutional Inpatient]
File Edit View Forms Tools Window Help
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 Hdr 6 Hdr 7 Hdr 8 Pat Srv 1
Patient ID
Last Name First Name MI
Date of Birth 00/00/0000
Gender
Add
Copy
Delete
Undo All
Save
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Find...
Print
Close

The Pat screen is added to the form if you selected **Y** in the Newborn Indicator field on the Header 5 screen.

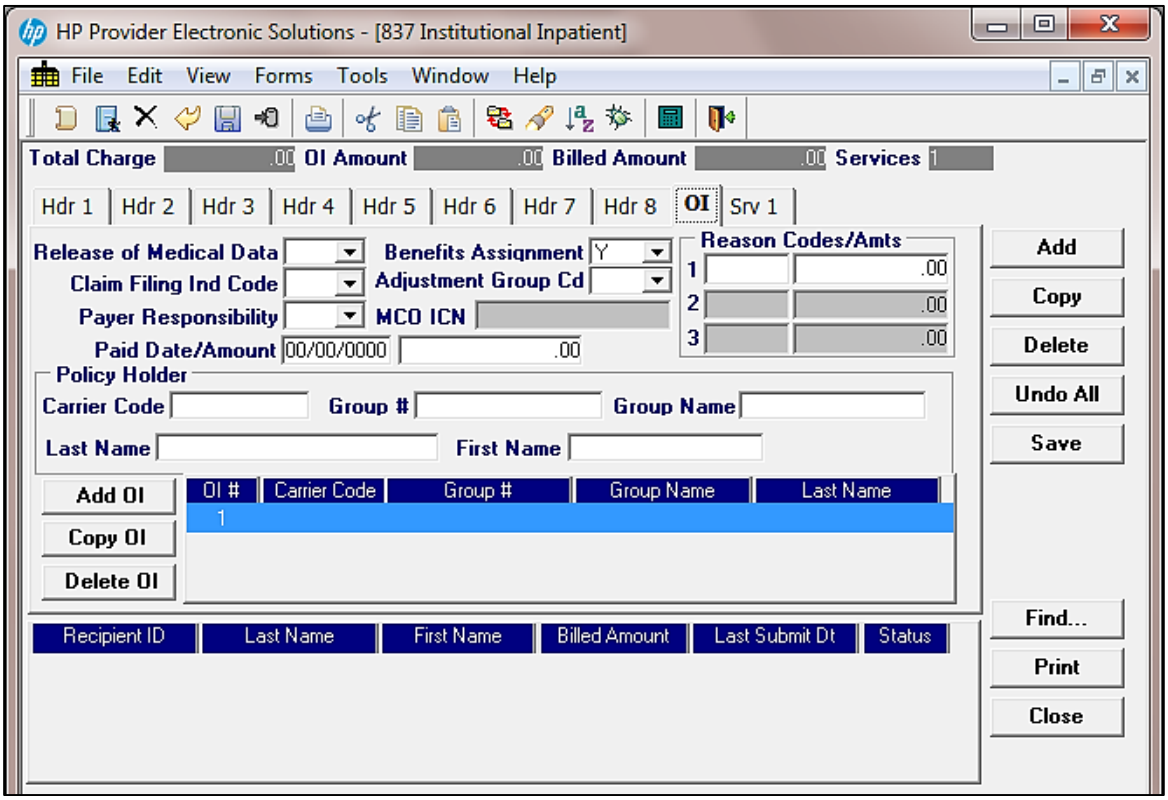
Step 10.1 Click the **Pat** tab to access the Newborn screen.

Patient ID	Enter the recipient ID of the newborn. If the newborn recipient does not have an ID number, leave this field blank. When the claim is submitted this field automatically populates with the mother's recipient ID number.
Last Name	Enter the newborn's last name.
First Name	Enter the newborn's first name.
MI	Enter the newborn's middle initial.
Date of Birth	Enter the newborn's date of birth. The format is the 2-digit month, 2-digit day, and 4-digit year.
Gender	Select the appropriate gender from the drop down box, or enter an appropriate value as specified, as described below: **F** – Female

	M – Male **U** – Unknown

The Other Insurance screen is added to the form if you selected **Y** in the Other Insurance Indicator field on the Header 5 screen. Access the Other Insurance screen by clicking the OI tab. The Other Insurance screen is displayed.

Step 11. Complete Other Insurance.



Release of Medical Data	Select the release code from the drop down list, or enter an appropriate value as specified, as described below: Select **I** – Informed Consent to Release Medical Info. For Conditions or Diagnoses Regulated by Federal Statutes Select **Y** — Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. Use if the provider has a signed statement on file from the recipient that authorizes the release of medical data to other organizations.
Benefits Assignment	Select the assignment code from the drop down list, or enter an appropriate value as specified, as described below: Select **Y** — Yes, if the recipient, or authorized person, has authorized that benefits be assigned to the provider.

	Select **N** — No, if the recipient, or authorized person, has not authorized that benefits be assigned to the provider. Select **W** for Not Applicable – Not applicable for this claim.	
Claim Filing Indicator Code	Select the appropriate claim code from the drop down list, or enter an appropriate value as specified. The claim code identifies the type of other insurance claim that is being submitted. **Note:** Consolidated Community Reporting for OMHSAS (CCR) - submitters must use the Claim Filing Indicator Code "HM". Using "HM" activates the MCO ICN field.	
	MC – Medicaid **11** – Other Non-Federal Program **12** – Preferred Provider Organization (PPO) **13** – Point of Sale (POS) **14** – Exclusive Provider Organization (EPO) **15** – Indemnity Insurance **16** – Health Maintenance Organization (HMO) Medicare Risk **17** – Dental Maintenance Organization **AM** – Automotive Medical **BL** – Blue Cross/ Blue Shield	**CH** - CHAMPUS **CI** – Commercial Insurance Co. **DS** – Disability **FI** – Federal Employees Program **HM** – Health Maintenance Organization **LM** – Liability Medical **MA** – Medicare Part A **MB** – Medicare Part B **OF** – Other Federal Program **TV** – Title V **VA** – Veteran Administration Plan **WC** – Worker's Compensation Health Claim **ZZ** – Mutually Defined
Adjustment Group Cd	Adjustment group code identifies the general category of the adjustment being made to the claim. Select the adjustment group code from the drop down list or, enter an appropriate value as specified: **CO** – Contractual Obligations **CR** – Correction and Reversals **OA** – Other Adjustments **PI** – Payer Initiated Reductions **PR** – Patient Responsibility	

Reason Codes/Amts, Fields 1-3	There are three Reason Code/Amount fields. Each field is divided into two segments. In the left segment of the field, select the appropriate reason code from the segment's drop down list or enter an appropriate value as specified. The reason code identifies the reason the adjustment is being made to the claim line, as described below: **1** – Deductible Amount **118**-ESRD Network Support Adjustment **119** – Benefit Maximum for this time period has been reached **2** – Coinsurance Amount **23** – Payment adjusted because charges were paid by another payer **3** – Copayment Amount **35** – Lifetime Benefits Maximum has been reached **45** - Charge exceeds fee schedule/maximum allowable **50** – Non-covered services In the right segment of the field, enter a numeric value for the amount of the adjustment using a decimal point. For example, enter 100.00 if the adjustment amount was $100.
Payer Responsibility	Level of payer responsibility for the recipient's other insurance. Select the appropriate code from the drop down list, or enter an appropriate value as specified: **P** – Payer 1 **S** – Payer 2 **T** – Payer 3 **A** – Payer 4 **B** – Payer 5 **C** – Payer 6 **D** – Payer 7 **E** – Payer 8 **F** – Payer 9 **G** – Payer 10 **H** – Payer 11 **U** - Unknown
MCO ICN	The MCO ICN field contains the internal claim number assigned to the claim when the managed care organization processed the claim from a provider. Consolidated Community Reporting for OMHSAS (CCR) submitters must enter a MCO ICN.

	Note: The MCO ICN field is activated when "RP" is indicated on Hdr 2 AND has a payer on the OI tab with Claim Filing Indicator code "HM". Without these conditions being met, the MCO ICN field will remain disabled.
Paid Date/Amount	This field is divided into two segments. In the left segment of the field, enter the 2-digit month; 2-digit day, and 4-digit year, that the recipient's third party insurance carrier paid the claim. For example, enter 10012015 if the date was October 1, 2015. Enter the amount paid by the other insurance carrier in the right segment of the field, using a decimal point. For example, enter 100.50 if the paid amount was $100.50. An amount of 0 (zero) may be entered. If a third party insurance carrier paid $0.00, you still should complete the Paid Date/Amount field with the date of the third party insurance carrier's explanation of benefits (EOB) denial, and the amount of 0.00.
Carrier Code (Policy Holder)	Resource code that identifies the third party insurance carrier. This field is automatically populated after you select or enter a group number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
Group # (Policy Holder)	Select the group number for the third party insurance from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.
Group Name (**Policy Holder)**	Name of the group or business that makes the insurance available to the insured person – this is not the third party insurance carrier. This field is automatically populated after you select or enter a Group Number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
Last Name (Policy Holder)	Policyholder's last name. This field is automatically populated after you select or enter a group number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*

First Name (Policy Holder)	Policyholder's first name. This field is automatically populated after you select or enter a group number. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policyholder form.

Step 11.1 To add another other insurance line click Add OI. A new blank service line is added to the screen.

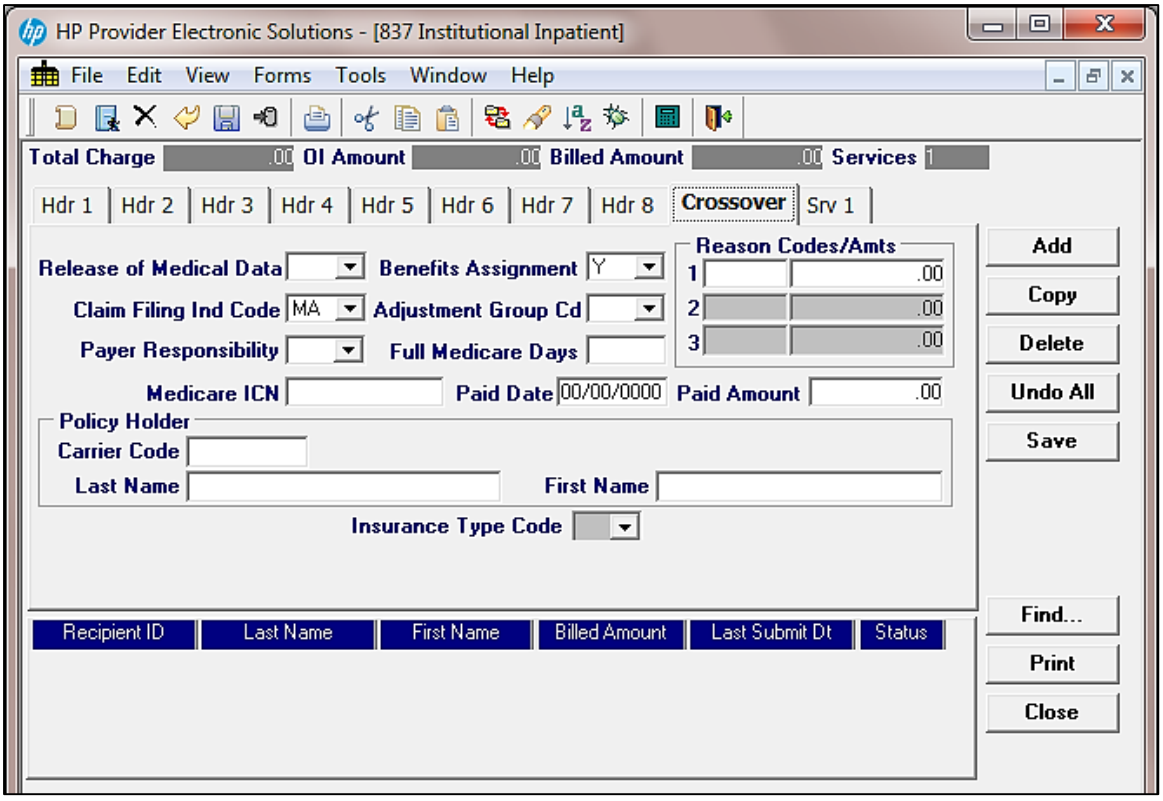
Click on the new service line and then enter the other insurance data in the appropriate data fields, as described in this step.

Step 11.2 To copy the data from an existing other insurance line to a new service line, click on the existing service line you want to copy and then click Copy OI. A new service line is added to the screen.

The new service line has the same data as the existing service line you previously selected. You can edit the data in the new service line. Simply click on the new service line and make changes to the appropriate fields.

Step 11.3 To delete an existing other insurance line, click on the service line you want to delete and then click Delete OI. The selected service line is deleted.

Step 12. Complete Crossover.



The Crossover screen is added to the claim if you selected **Y** in the Crossover Ind field on the Header 3 screen. Access the Crossover screen by clicking the Crossover tab. The Crossover screen is displayed.

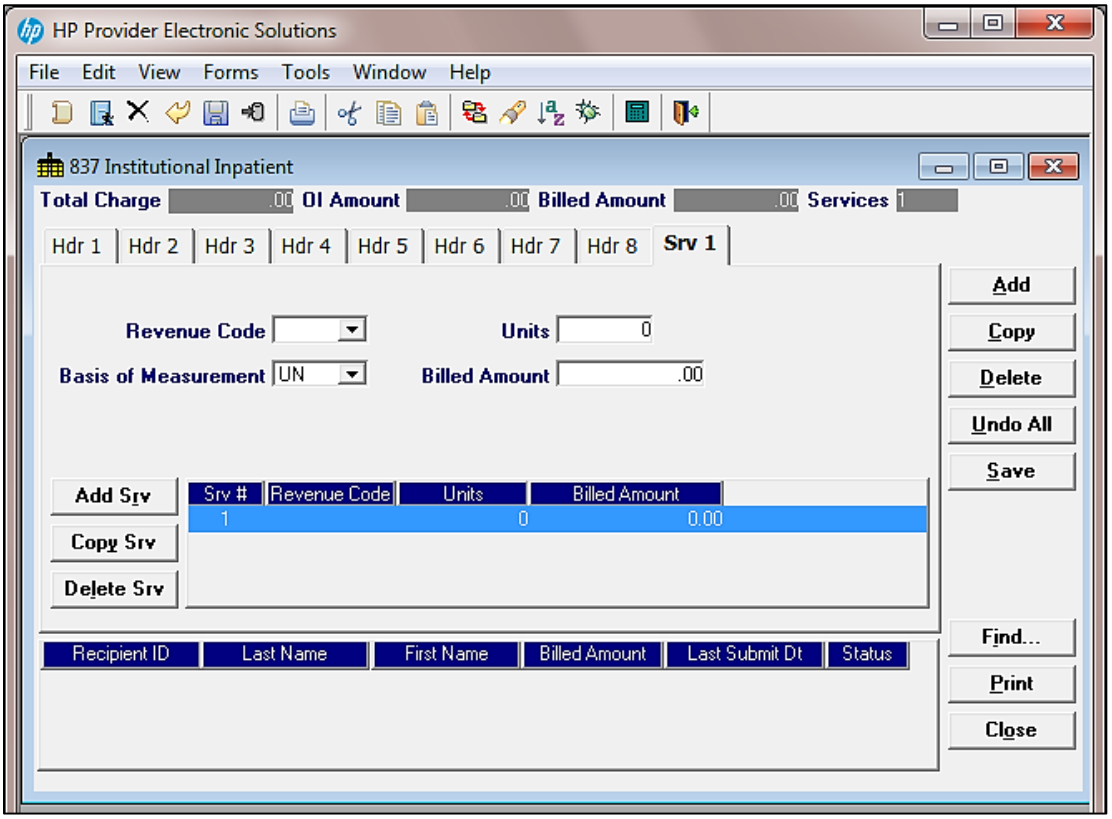
Release of Medical Data	Select the appropriate release code from the drop down list, or enter an appropriate value as specified: Select **I -** Informed Consent to Release Medical Information – for conditions or diagnosis regulated by Federal statutes. Select **Y -** Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. The provider has a signed statement on file permitting the release of medical data to other organizations
Benefits Assignment	Select the appropriate assignment code from the drop down list or enter an appropriate value as specified: Select **Y** – Yes - if the recipient, or authorized person, has authorized that benefits be assigned to the provider. Select **N** – No - if the recipient, or authorized person, has not authorized that benefits be assigned to the provider. Select **W** for Not Applicable – Not applicable for this claim.
Reason Codes/Amts, Fields 1-3	There are three Reason Code/Amount fields. Each field is divided into two segments. In the left segment of the field, select the appropriate reason code from the segment's drop down list or enter an appropriate value as specified. The reason code identifies the reason the adjustment is being made to the claim line, as described below: **1** – Deductible Amount **118**-ESRD Network Support Adjustment**119** – Benefit Maximum for this time period has been reached **2** – Coinsurance Amount **23** – Payment adjusted because charges were paid by another payer **3** – Copayment Amount **35** – Lifetime Benefits Maximum has been reached **45 -** Charge exceeds fee schedule/maximum allowable **50** – Non-covered services In the right segment of the field, enter the amount of the adjustment, using a decimal point. For example, enter 105.50 if the adjustment amount was $105.50.

Claim Filing Indicator Code	Select the appropriate claim code from the drop down list, or enter an appropriate value as specified. The claim code identifies the type of other insurance claim that is being submitted. **Note:** Consolidated Community Reporting for OMHSAS (CCR) - submitters must use the Claim Filing Indicator Code "HM". Using "HM" activates the MCO ICN field. **MC** – Medicaid **11** – Other Non-Federal Program **12** – Preferred Provider Organization (PPO) **13** – Point of Sale (POS) **14** – Exclusive Provider Organization (EPO) **15** – Indemnity Insurance **16** – Health Maintenance Organization (HMO) Medicare Risk **17** – Dental Maintenance Organization **AM** – Automotive Medical **BL** – Blue Cross/ Blue Shield **CH** - CHAMPUS **CI** – Commercial Insurance Co. **DS** – Disability **FI** – Federal Employees Program **HM** – Health Maintenance Organization **LM** – Liability Medical **MA** – Medicare Part A **MB** – Medicare Part B **OF** – Other Federal Program **TV** – Title V **VA** – Veteran Administration Plan **WC** – Worker's Compensation Health Claim **ZZ** – Mutually Defined
Adjustment Group Cd	Identifies the general category of the adjustment being made to the claim. Select the adjustment group code from the drop down list or enter an appropriate value as specified: **CO** – Contractual Obligations **CR** – Correction and Reversals **OA** – Other Adjustments **PI** – Payer Initiated Reductions **PR** – Patient Responsibility

Payer Responsibility	Payer responsible for the recipient's other insurance. Select the appropriate code from the drop down list, or enter an appropriate value as specified: **P** – Payer 1 **S** – Payer 2 **T** – Payer 3 **A** – Payer 4 **B** – Payer 5 **C** – Payer 6 **D** – Payer 7 **E** – Payer 8 **F** – Payer 9 **G** – Payer 10 **H** – Payer 11 **U** – Unknown
Full Medicare Days	Enter the total number of days during the service month that were fully covered by Medicare. This field is not currently used on the Institutional Inpatient claim. Please leave it blank.
Medicare ICN	Enter the Medicare ICN from the Medicare explanation of medical benefits (EOMB) for the service being billed.
Paid Date	Enter the 2-digit month, 2-digit day, and 4-digit year the Medicare coinsurance was paid. This information can be found on the Medicare EOMB.
Paid Amount	Enter the Medicare coinsurance amount, using a decimal point. This information can be found on the Medicare EOMB. For example, enter 5.00 if the paid amount was $5.00. An amount of 0 (zero) may be entered.
Carrier Code (Policy Holder)	Select the carrier code from the drop down list, or enter an appropriate value as specified. The carrier code identifies the recipient's third party insurance carrier. **Note:** Carrier Codes can be added or deleted (as Required) from the Lists as described in Section 7 REFERENCE LISTS on page 40.
Last Name (Policy Holder)	Policyholder's last name. This field is automatically populated after you select or enter a carrier code in the Group # field.

	Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.
First Name (Policy Holder)	Policyholder's first name. This field is automatically populated after you select or enter a carrier code in the Group # field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
Insurance Type Code (Policy Holder)	The window is only active if the payer is Medicare with Claim filing code of MB and the Payer Responsibility is not P (Primary). Select the appropriate value from the dropdown box that identifies the type of insurance listed. **12** – Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan **13** –Medicare Secondary, End-Stage Renal Disease in the Mandated Coordination Period with an Employer's Group Health Plan **14** – Medicare Secondary, No-fault Insurance including Auto is Primary **15** – Medicare Secondary, Worker's Compensation **16** – Medicare Secondary Public Health Service (PHS) or Other Federal Agency **41** – Medicare Secondary Black Lung **42** – Medicare Secondary Veteran's Administration **43** – Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) **47** – Medicare Secondary, Other Liability Insurance is Primary

Step 13. Complete Service 1.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Inpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 Hdr 6 Hdr 7 Hdr 8 Srv 1
Revenue Code
Units 0
Basis of Measurement UN
Billed Amount .00
Add Srv
Copy Srv
Delete Srv
Srv # Revenue Code Units Billed Amount
1 0 0.00
Add
Copy
Delete
Undo All
Save
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Find...
Print
Close

Revenue Code	Enter the code that identifies a specific accommodation or ancillary service. This field accepts a maximum of four numeric characters. **0100** – Facility Days **0183** – Leave Days **0185** – Hospital Days
Units	Enter the number of units provided to the recipient for the service being billed. For example, enter **1** if one unit was provided to the recipient. Zero (0) units is a permitted value.
Basis of Measurement	Select the basis code from the drop down list, or enter an appropriate value as specified. This field identifies the units in which a value is being expressed, or the manner in which a measurement has been taken. **DA** – Days (Institutional) **UN** – Unit (Institutional and Professional)
Billed Amount	Enter the usual charge to the self-paying public for the service(s) provided, using a decimal point. If billing for multiple units, multiply the usual charge by the number of units billed and enter that amount. A zero (0.00) billed amount is a permitted value.

Step 13.1 To add additional service lines with revenue codes, click Add Srv. A new blank service line is added to the screen.

Step 13.2 Click on the new service line and then enter the service data in the appropriate data fields, as described in this step.

Step 13.3 To copy the data from an existing service line to a new service line, click on the existing service line you want to copy and then click Copy Srv. A new service line is added to the screen.

The new service line has the same data as the existing service line you previously selected. Edit the data in the new service line by clicking on the new service line, and then enter changes to the appropriate fields.

Step 13.4 To delete an existing service line, click on the service line you want to delete and then click Delete Srv. The selected service line is deleted.

Step 14. Click Save to save the institutional inpatient form.

Step 15. Click Add to start another institutional inpatient claim.

9.6 Complete an 837 Institutional Nursing Facility Form

Use the 837 Institutional Nursing Facility form to create claims for institutional nursing home services. The 837 Institutional Nursing Facility form is divided into seven screens. Each screen contains the following claim data:

Hdr 1	Accesses the screen that contains the provider and resident information.
Hdr 2	Accesses the screen that contains the admission, days, Attending Provider and Rendering provider.
Hdr 3	Accesses the screen that contains any diagnosis information.
Hdr 4	Accesses the screen that contains any occurrence, condition, and value code information.
Hdr 5	Access the screen that contains Additional Diagnosis Codes 2 - 12
O/I	Accesses the screen that contains any other insurance carrier information.
Crossover	Accesses the screen that contains Medicare information. It can be accessed by selecting "**Y**", in the Crossover Ind field, located under the Header 3.
Srv 1	Accesses the screen that contains billing information.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

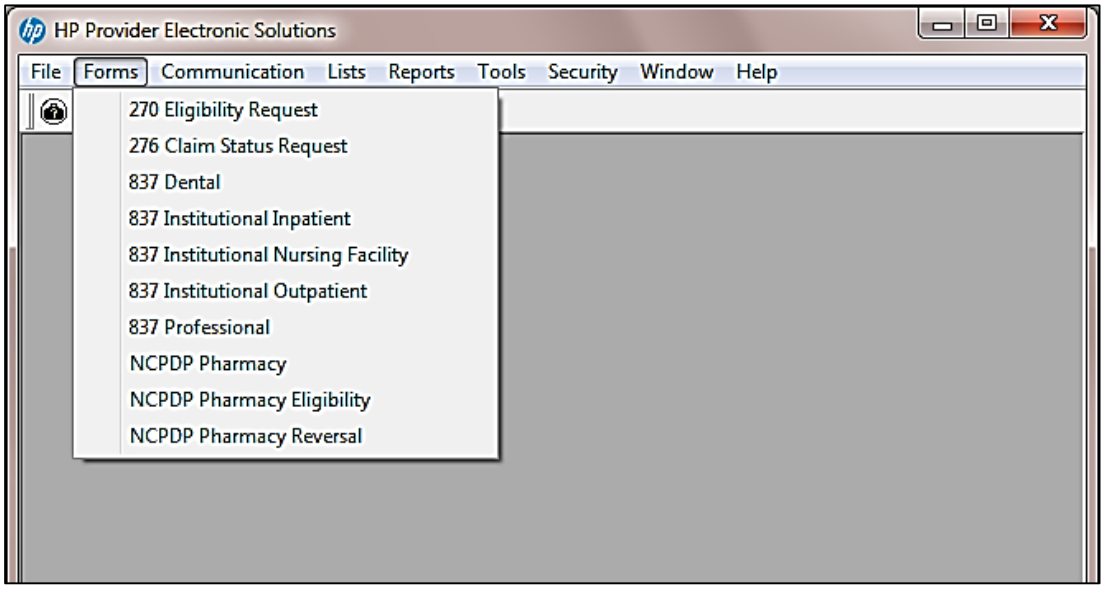
To create an institutional nursing facility claim, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, access the 837 Institutional Nursing Facility Form either in one of two ways:

Click (837 Institutional Nursing Facility Shortcut icon) on the Toolbar

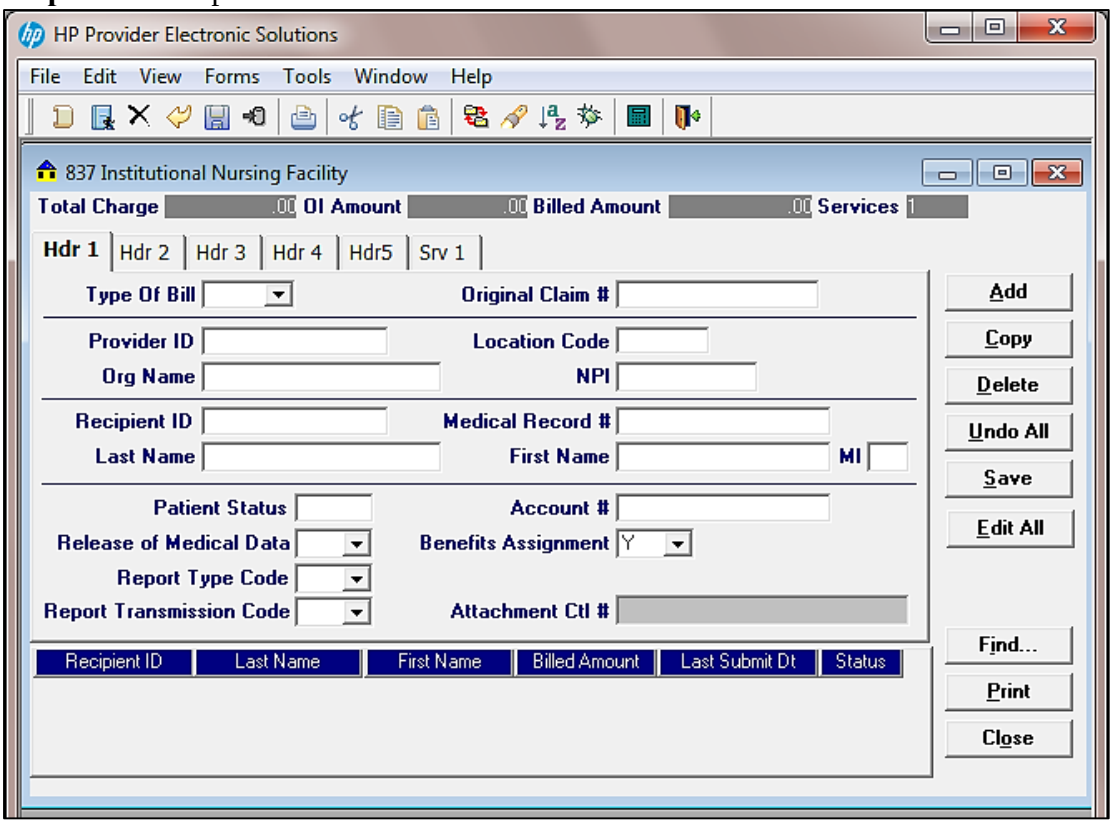
or

Select the **837 Institutional Nursing Facility** Option from the **Forms** drop down menu.



Note: When you choose a selection from a drop down list (as indicated in the field completion instructions below) many of the fields are completed. A drop down list is also known as a reference list. For additional information on reference lists, refer to the List options under Section 6.

Step 2. Complete Header 1.



Type of Bill Code	Enter the code that identifies the type of bill or choose the appropriate code from the drop down list as described below. Select the appropriate Type of Bill codes for the transaction type from the table below or enter an appropriate value as specified.	
	Form Name	**Type of Bill Codes**
	837 Institutional Nursing Facility (County and General Nursing Facilities, State Mental Hospitals)	County Nursing Facilities, General Nursing Facilities, State Mental Facilities use a type of bill code that starts with 26. 260 Nursing Home – Zero/No Pay Claim 261 Nursing Home – Admit Through Discharge Claim 262 Nursing Home – Interim First Claim 263 Nursing Home – Interim Continuing Claim 264 Nursing Home – Interim Last Claim 267 Nursing Home – Replacement of Prior Claim

		268 Nursing Home – Void/Cancel of Prior Claim
	Intermediate Care Facilities (State Mental Retardation Centers, ICF/MR Facilities, ICF/ORC Facilities)	**Intermediate Care Facilities, State Mental Retardation Centers, ICF/MR Centers, and ICF/ORC Centers** 650 ICF/MR – Zero/No Pay Claim 651 ICF/MR – Admit Through Discharge Claim 652 ICF/MR – Interim First Claim, 653 ICF/MR – Interim Continuing Claim 654 ICF/MR – Interim Last Claim 657 ICF/MR – Replacement of Prior Claim 658 ICF/MR – Void/Cancel of Prior Claim **Note:** The last digit should be selected based on the definitions below: 0 – Non Payment/Zero Claim – This code should be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill. 1 – Admit Through Discharge Claim – This code should be used for a bill that is expected to be the only bill received for a course of treatment or confinement. 2 – Interim/First Claim – This code is to be used for the first of a series of bills to the same payer for the same confinement. 3 – Interim/Continuing Claim – This code is to be used for when a bill for the same confinement or course of treatment will be submitted. 4 – Interim/Last Claim – This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that no further bills for the same confinement or course of treatment will be submitted. 7 – Replacement of a Prior Claim – This code is to be used when a bill has been submitted and paid and needs to be adjusted. 8 – Void/Cancel of Prior Claim – This code reflects the elimination of a previously submitted bill.

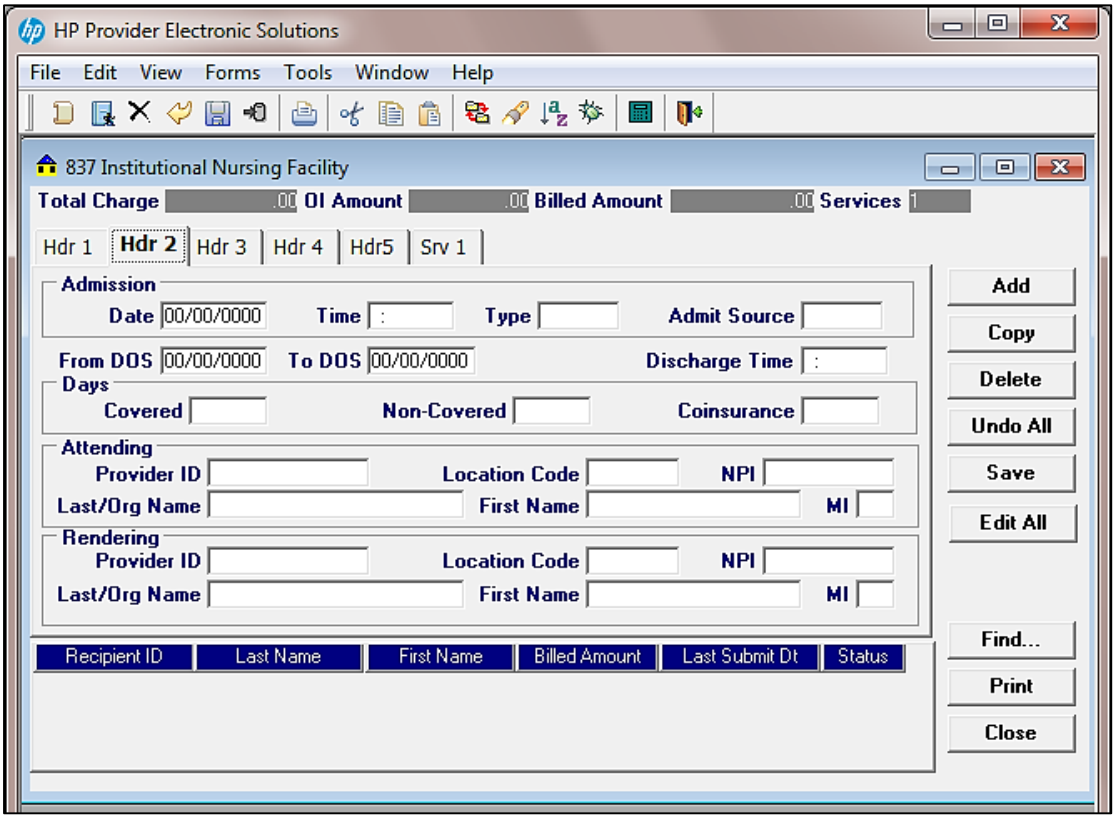
Original Claim #	Enter the 13-digit original ICN. When submitting a previously rejected claim, or a claim adjustment that was adjudicated **prior** to the implementation of PROMISe™, enter the 10-digit CRN followed by the 2-digit line number, as printed on the RA statement.
Provider ID	Select the 8- or 9-character Medical License Number of the other provider from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. **Note**: For Access Plus Referred Services, select the 13-digit MAID number for the referring provider from the field's pull down list.
Location Code	4-digit location code associated with the MPI number selected in the Provider ID field. This field is automatically populated after you select or enter an MPI number in the Provider ID (Other) field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Org Name	Provider's organization name or the group name. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Recipient ID	The recipient's 10-digit recipient number. For additional information on the Recipient ID field, refer to *Recipient Reference List* in section 8.3 of this manual. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Medical Record Number	Medical record number assigned to the recipient by your facility. This field is automatically populated after you select or enter a recipient ID. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
Last Name	Recipient's last name. This field is automatically populated after you select or enter a recipient ID. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*

First Name	Recipient's first name. This field is automatically populated after you select or enter a recipient ID. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
Middle Initial	Recipient's middle initial. This field is automatically populated after you select or enter a recipient ID. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
Patient Status	Recipient's status on the last date of service billed on this claim. Enter the appropriate 2-digit status code or select the status code from the drop down list or enter an appropriate value as specified: **01** – Dischrgd to home or self-care (routine discharge) **02** – Dischrgd/trnsfrrd to another hospital for inpatient care **03** – Dischrgd/transfrrd to skilled nursing facility **04** – Dischrgd/transfrrd to an intermediate care facility **05** – Dischrgd/transfrrd to another type of institution **07** – Left against medical advice or discontinued care **20** – Expired **30** – Still a patient
Account Number	Enter the patient's alpha, numeric, or alphanumeric number assigned by the provider. You may enter up to 30 characters. MA captures and returns 30 characters. When this field is completed, the patient's account number appears on the RA statement, and makes it easier to identify those invoices where the recipient number is not recognized. **Note:** An account number is required for each claim to be able to obtain claim status information. If the same account number is used for each claim submitted, when a claim status request is sent, the claim status is reported on **all** claims with that account number.
Release of Medical Data	Select the appropriate release code from the drop down list or enter an appropriate value as specified: Select **I** – Informed Consent to Release Medical Information Select **Y** – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim – Use if the provider has a signed statement on file permitting the release of medical data to other organizations.
Benefits Assignment	Select the appropriate assignment code from the drop down list or enter an appropriate value as specified,:

	Select **Y** – Yes - if the recipient, or authorized person has authorized benefits to be assigned to the provider. Select **N**, **–** No - if the recipient or authorized person does not have authorized benefits to be assigned to the provider. Select **W** for Not Applicable – Not applicable for this claim.
Report Type Code	Enter the appropriate code for the type of attachment submitted from the drop down list or enter an appropriate value as specified : **AS** – Admission Summary **B2** – Prescription **B3** – Physician Order **B4** – Referral Form **CT** – Certification **DA** – Dental Models **DG** – Diagnostic Report **DS** – Discharge Summary **EB** – Explanation of Benefits **MT** – Models **NN** – Nursing Notes **OB** – Operative Notes **OZ** – Support Data for Claim **PN** – Physical Therapy Notes **PO** – Prosthetics or Orthotic Certification **PZ** – Physical Therpy Certification **RB** – Radiology Films **RR** – Radiology Reports **RT** – Reports of Tests and Analysis Report
Report Transmission Code	Enter the appropriate code for the method of attachment transmission from the drop down list or enter an appropriate value as specified:: **AA** – Available on Request at Provider Site **BM** – By Mail **EL** – Electronically Only **EM** – E-Mail **FT** – File Transfer **FX** – By Fax
Attachment Control #	Enter the (up to) 10-digit number obtained from the PROMISe™ web site. This number is used when a paper attachment is required by MA to cross-

	reference the paper attachment with the electronic claim. This number also must be written on the cover letter sent to MA.

Step 3. Complete Header 2.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Nursing Facility
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr5 Srv 1
Admission
Date 00/00/0000 Time : Type Admit Source
From DOS 00/00/0000 To DOS 00/00/0000 Discharge Time :
Days
Covered Non-Covered Coinsurance
Attending
Provider ID Location Code NPI
Last/Org Name First Name MI
Rendering
Provider ID Location Code NPI
Last/Org Name First Name MI
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Edit All
Find...
Print
Close

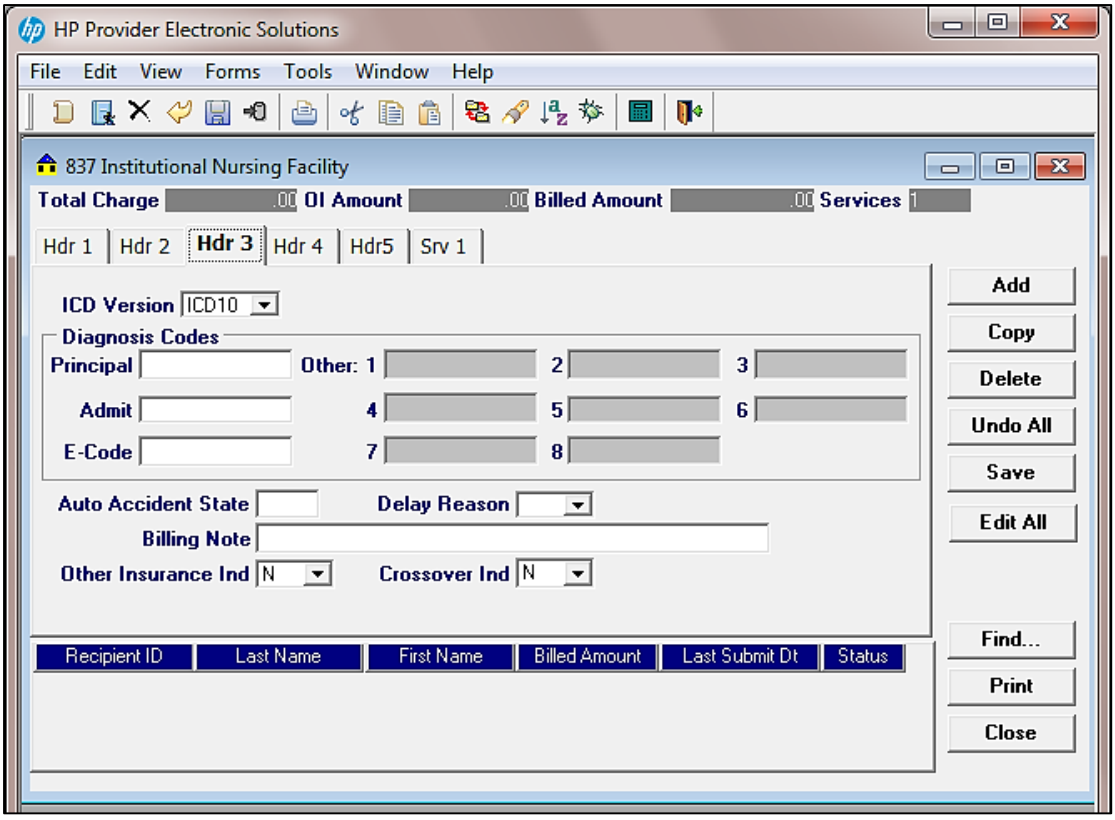
Date (Admission)	Enter the 2-digit month, 2-digit day, and 4-digit year the resident was originally admitted to the facility. For example, enter 10012015 if the date was October 1, 2015.
Time (Admission)	Enter the hour that the resident was admitted to the facility. The hour codes are in military (twenty-four-hour) time. For example: 12:00 – 12:59 – Midnight = **00:00 – 00:59** 12:00 – 12:59 – Noon = **12:00 – 12:59** 6:00 – 6:59 p.m. 6:00 p.m. = **18:00 – 18:59**
Type (Admission)	Enter the code that identifies the type of admission to the facility or choose the appropriate code from the field's preloaded drop down list or enter an appropriate value as specified:

	1 – Emergency Admission. An emergency admission is defined as the patient's condition requires immediate medical attention and any time delay would be harmful to the patient. **2** – Urgent Admission. An urgent admission is defined when the resident's condition, while not immediately essential, should have medical attention provided very early to prevent possible loss or impairment of life, limb, or body function. **3** – Elective Admission. An elective admission is defined as a scheduled or planned admission. **4 –** Newborn **5** – Trauma Center
Admit Source (Admission)	Enter the code that identifies the source of admission to the facility, or choose the appropriate code from the field's preloaded drop down list or enter an appropriate value as specified: **1** – Physician Referral **2** – Clinic Referral **3** – HMO Referral **4** – Transfer from a Hospital **5** – Transfer from a Skilled Nursing Facility **6** – Transfer from Another Healthcare Facility **7** – Emergency Room **8** – Court/Law **9** – Information Not Available **A** – Transfer from a Rural Primary Care Hospital
From DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the resident first received service under this claim. For example, enter 10012015 if the date was October 1, 2015. If the same service was provided on consecutive days, enter the first day of the service in this field and the last day of service in the To DOS field. If you bill for a service that was provided on only one day, complete the From DOS field with the date of service and press the **Tab** key. The same date is populated automatically in the To DOS field.
To DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the resident last received service under this claim. For example, enter 10312015 if the date was October 31, 2015. The From DOS and To DOS should equal Covered Days + Non-covered Days + Co-insurance Days + Full Medicare Days.

Discharge Time	Enter the hour during which the patient was discharged. Enter the hour in military (twenty-four-hour) time. For example: 12:00 – 12:59 – Midnight = **00:00 – 00:59** 12:00 – 12:59 – Noon = **12:00 – 12:59** 6:00 – 6:59 - 6:00p.m. = **18:00 – 18:59**
Covered	Enter the number of days covered by MA. **The discharge day should not be counted as a covered day.** This field accepts up to three numeric characters. This field should equal Facility Days + Hospital Reserved Bed Days + Therapeutic Leave Days.
Non-Covered	Enter the total number of days during the service month that were not covered by Medicare or MA. Days that should be counted as non-covered days are: • Therapeutic leave days that exceed 30 days per calendar year. • The number of hospital reserved bed days that are greater than 15 consecutive days, and/or • The number of days paid in full by a third party liability. Co-insurance days are NOT accounted for in the Covered or Non-Covered fields. These days are recorded on the **Crossover Screen**.
Co-insurance	Enter the number of Medicare coinsurance days that apply to this service month. This field accepts up to three numeric characters. Days that should be counted as co-insurance days are any Medicare co-insurance days that occur between days 21 and 100 of the resident's stay.
Provider ID (Attending Provider)	Provider who attends to the resident. Select the attending provider's 8- or 9-character medical license number.
Location Code (Attending Provider)	The 4-digit code for the location where the attending provider performed the service.
NPI (Attending Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Attending Provider)	Attending provider's last name. This field is automatically populated after you select or enter a medical license number in the Provider ID (Attending Provider) field.

	Information cannot be entered directly *into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Attending Provider)	Attending provider's first name. This field is automatically populated after you select or enter a medical license number in the Provider ID (Attending Provider) field. *Information cannot be entered* directly *into this field. If you need to add or edit information in this field, access the Provider Form.*
MI (Attending Provider)	Attending provider's middle initial. This field is automatically populated after you select or enter a medical license number in the Provider ID (Attending Provider) field. *Information cannot be* entered *directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Provider ID (Rendering Provider)	Select the rendering provider's 8- or 9-character medical license number.
Location Code (Rendering Provider)	The 4-digit code for the location where the rendering provider performed the service.
NPI (Rendering Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Rendering Provider)	Rendering provider's last name. This field is automatically populated after you select or enter a medical license number in the Provider ID (Rendering Provider) field. *Information* cannot *be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Rendering Provider)	Rendering provider's first name. This field is automatically populated after you select or enter a medical license number in the Provider ID (Rendering Provider) field. *Information* cannot *be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
MI (Rendering Provider)	Rendering provider's middle initial. This field is automatically populated after you select or enter a medical license number in the Provider ID (Rendering Provider) field. *Information cannot be* entered *directly into this field. If you need to add or edit information in this field, access the Provider Form.*

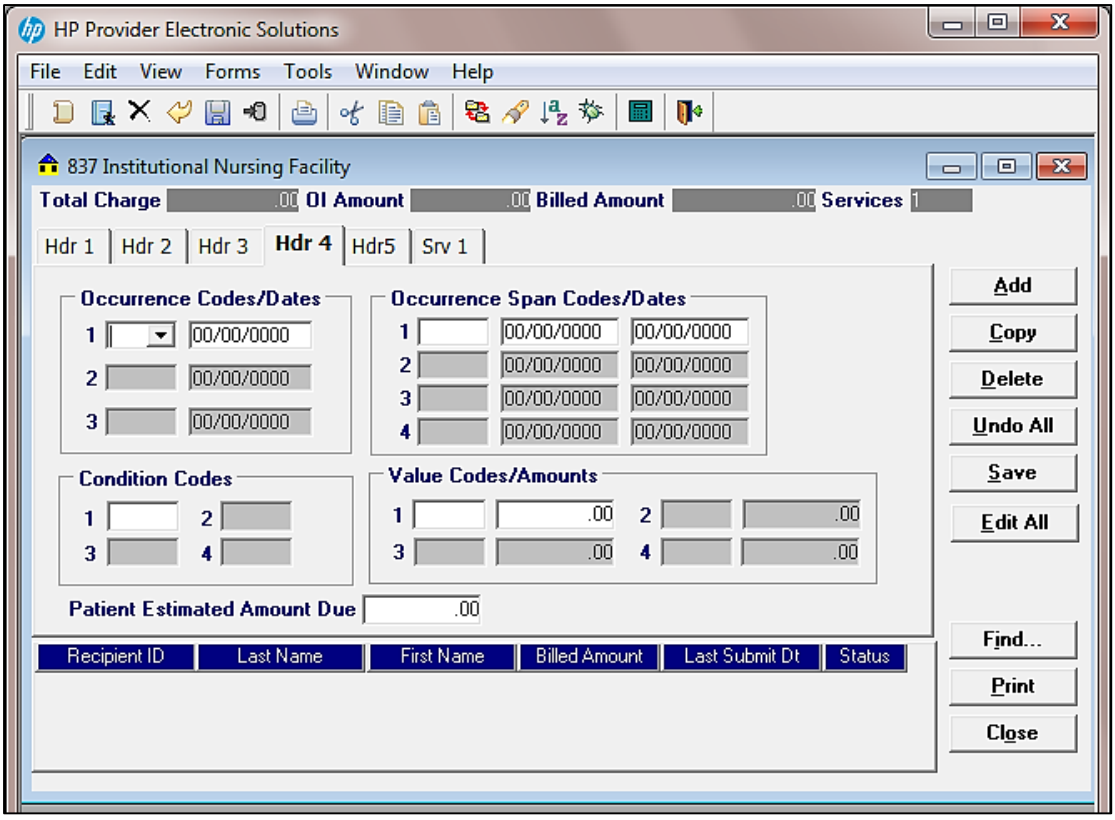
Step 4. Complete Header 3.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Nursing Facility
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr5 Srv 1
ICD Version ICD10
Diagnosis Codes
Principal Other: 1 2 3
Admit 4 5 6
E-Code 7 8
Auto Accident State Delay Reason
Billing Note
Other Insurance Ind N Crossover Ind N
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Edit All
Find...
Print
Close

ICD Version	Use the ICD 9/ICD10 Version for the code being submitted.
Principal (Diagnosis Codes)	Principal (primary) diagnosis code is the most specific I ICD-9-CM/ICD-10-CM/PCS diagnosis code that relates to a recipient's stay. Select the principal diagnosis code from the drop down list, or enter an appropriate value as specified.
Other, Fields 1-8 (Diagnosis Codes)	Each Other field identifies an additional diagnosis code for the form. Select each additional diagnosis code from the drop down lists, or enter the appropriate value(s) or enter an appropriate value as specified.
Admit (Diagnosis Codes)	Admission code is the ICD-9-CM/ICD-10-CM/PCS diagnosis code that corresponds to the diagnosis of the recipient's condition that prompted admission to the hospital. Select the admission diagnosis code from the drop down list, or enter an appropriate value as specified.
E-Code (Diagnosis Codes)	This code represents the external cause of injury. Enter the external diagnosis code or select the external code from the field's pull down list or enter an appropriate value as specified.

	Required on Institutional claims whenever a diagnosis is needed to describe an injury, poisoning, or adverse effect.
Auto Accident State	Enter the two-letter abbreviation for the state where the accident occurred. For example, enter **PA** for Pennsylvania.
Delay Reason	Enter the appropriate code to indicate why a claim is being submitted outside of the 180-day initial submission window. This is an optional field. **1**– Proof of Eligibility Unknown or Unavailable **2** – Litigation **3** – Authorization Delays
Billing Note	If the provider is a qualified small business, enter QSB in this field. This field is optional.
Other Insurance Indicator	Select the other insurance code from the drop down list, or enter an appropriate value as specified: Select **Y —** if the recipient has other insurance. Select **N —** if the recipient does not have other insurance.
Crossover Indicator	Populates the Crossover screen, which is used to record a recipient's Medicare information. Select the crossover code from the drop down list, or enter an appropriate value as specified: Select **Y —** if the recipient has Medicare. Select **N —** if the recipient does not have Medicare.

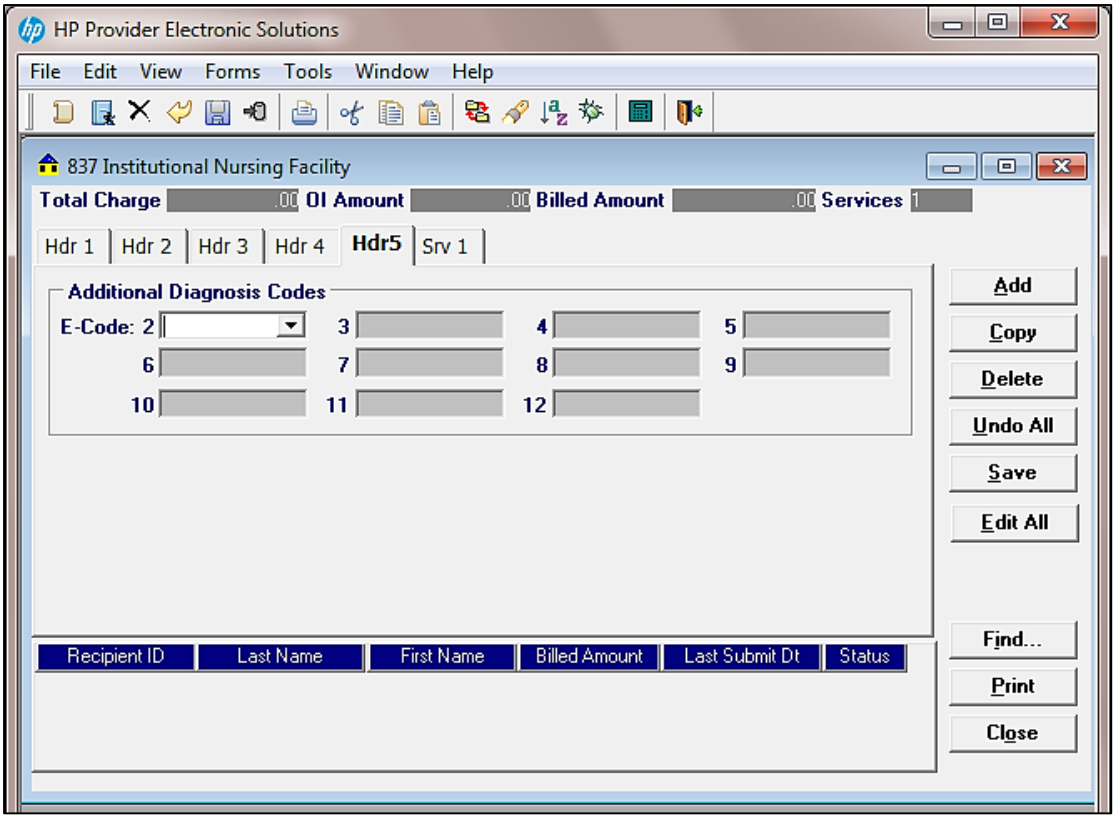
Step 5. Complete Header 4.



Occurrence Code/Dates	This field is not currently used in completing the 837 Institutional Nursing Facility Form.
Occurrence Span Codes/Dates, Fields 1-4	Each field is divided into three segments. In the left segment of the field, enter the appropriate occurrence span code as specified, or select the appropriate occurrence span code from the segment's drop down list, as described below: **74**– Non-covered Level of Care / Leave of Absence In the middle segment, enter the 2-digit month, 2-digit day, and 4-digit year in which the period of hospitalization began. In the right segment, enter the 2-digit month, 2-digit day, and 4-digit year in which the period of hospitalization ended. Break the period of hospitalization out by month if the hospitalization overlaps two consecutive months. If a claim for the month following the service month was previously approved for payment by MA, and contained

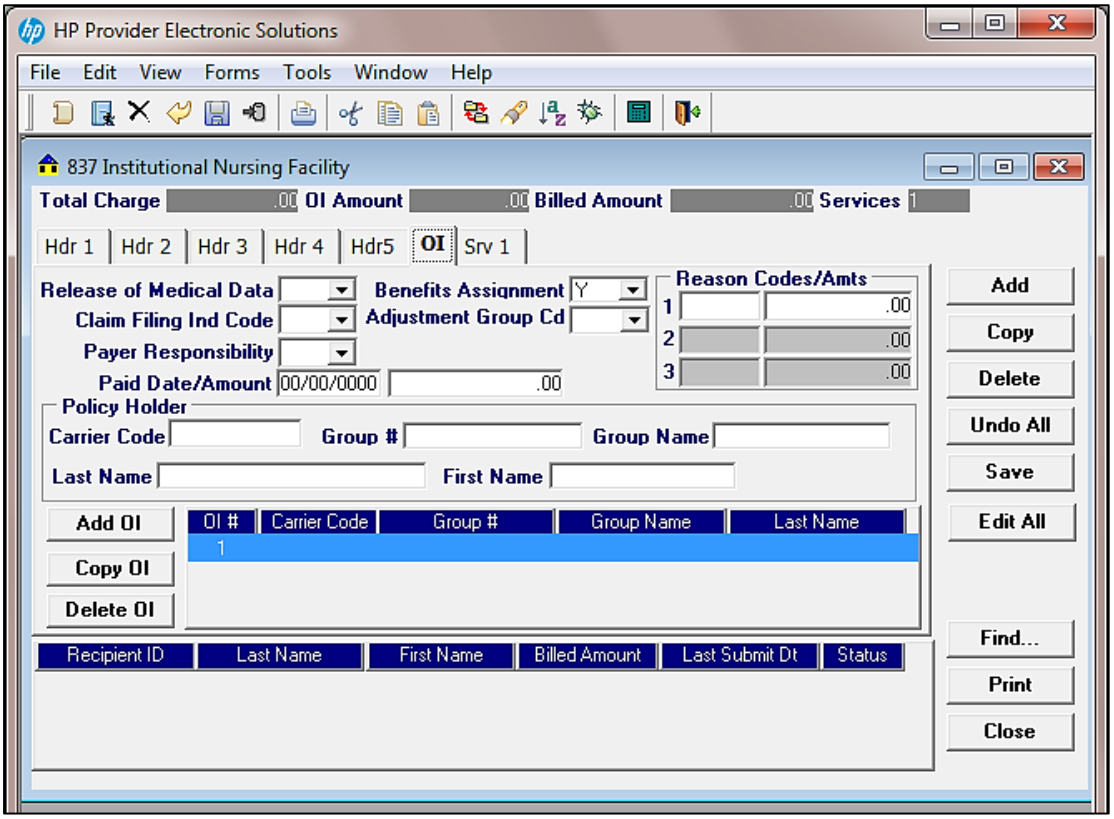
	periods of hospitalization, include these dates of hospitalization in the hospitalization items. The date of return to the facility is considered a facility day, not a hospital day.
Condition Codes, Fields 1-4	Condition codes are not used in Long Term Care billing. Please leave this field blank.
Value Codes/Amounts, Fields 1-4	Value codes are used to report drug deductions, insurance premiums, and other medical expenses. Value codes identify data of a monetary nature that is necessary for processing the form as required by the payer organization. Each field is divided into two segments. In the left segment of this field, enter the value code as specified or select the value code from the segment's drop down list, as described below. **06** – Medicare Blood Deductible **14** – No Fault Auto/Other **15** – Workman's Compensation **16** – PHS or Other Federal Agency **25** – Drug Deduction **31** – Patient Liability Amount **34** – Offset to Patient Payment Amount - Other Medical Expense **35** – Offset to Patient payment Amount – Health Insurance Premium **38** – Medicare Blood Deductible Pints Furnished **39** - Medicare Blood Deductible Pints Replaced **47** – Any Liability Insurance **66** – Patient Paid Amount In the right segment of this field, enter the dollar amount for each code, using a decimal point.
Patient Estimated Amount Due	Enter the gross patient pay amount for the claim.

Step 6. Complete Hdr 5



E-Code (Additional Diagnosis Codes 2-12)	Diagnosis code that describes the external cause of the recipient's injury. Select the external diagnosis code from the drop down list, or enter an appropriate value as specified.

Step 7. Complete Other Insurance.



The Other Insurance screen is added to the claim if you selected **Y** in the Other Insurance Indicator field on the Header 3 screen**.** Access the Other Insurance screen by clicking the OI tab

Release of Medical Data	Select the release code from the drop down list, or enter an appropriate value as specified: Select **I** – Informed Consent to Release Medical Information- Select **Y** – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim – Use if the provider has a signed statement on file permitting the release of medical data to other organizations.
Benefits Assignment	Select the assignment code from the drop down list, or enter an appropriate value as specified: Select **Y —** if the resident or authorized person has authorized that benefits be assigned to the provider. Select **N —** if the resident or authorized person has not authorized that benefits be assigned to the provider. Select **W** for Not Applicable – Not applicable for this claim.

Claim Filing Indicator Code	Select the appropriate claim code from the drop down list, or enter an appropriate value as specified. The claim code identifies the type of other insurance claim that is being submitted. **Note:** Consolidated Community Reporting for OMHSAS (CCR) - submitters must use the Claim Filing Indicator Code "HM". Using "HM" activates the MCO ICN field. **MC** – Medicaid **09** – Self-Pay **10** – Central Certification **11** – Other Non-Federal Program **12** – Preferred Provider Organization (PPO) **13** – Point of Sale (POS) **14** – Exclusive Provider Organization (EPO) **15** – Indemnity Insurance **16** – Health Maintenance Organization (HMO) Medicare Risk **AM** – Automotive Medical **BL** – Blue Cross/ Blue Shield **CH** - CHAMPUS **CI** – Commercial Insurance Co. **DS** – Disability **HM** – Health Maintenance Organization **LI** - Liability **LM** – Liability Medical **MA** – Medicare Part A **MB** – Medicare Part B **OF** – Other Federal Program **TV** – Title V **VA** – Veteran Administration Plan **WC** – Worker's Compensation Health Claim **ZZ** – Mutually Defined
Adjustment Group Cd	General category of the adjustment being made to the claim. Select the adjustment group code from the drop down list, or enter an appropriate value as specified: **CO** – Contractual Obligations **CR** – Correction and Reversals **OA** – Other Adjustments **PI** – Payer Initiated Reductions

	PR – Patient Responsibility
Payer Responsibility	Level of payer responsibility for the resident's other insurance. Select the appropriate code from the drop down list, or enter an appropriate value as specified: **P** – Payer 1 **S** – Payer 2 **T** – Payer 3 **A** – Payer 4 **B** – Payer 5 **C** – Payer 6 **D** – Payer 7 **E** – Payer 8 **F** – Payer 9 **G** – Payer 10 **H** – Payer 11 **U** – Unknown
Reason Codes/Amts, Fields 1-3	There are three Reason Code/Amount fields. Each field is divided into two segments. In the left segment of the field, select the appropriate reason code from the segment's drop down list, or enter an appropriate value as specified. The reason code identifies the reason the adjustment is being made to the claim line, as described below: **1** – Deductible Amount **118**-ESRD Network Support Adjustment**119** – Benefit Maximum for this time period has been reached **2** – Coinsurance Amount **23** – Payment adjusted because charges were paid by another payer **3** – Copayment Amount **35** – Lifetime Benefits Maximum has been reached **45 -** Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement **50** – Non-covered services Enter the amount of the adjustment in the right segment of the field, using a decimal point. For example, enter 105.50 if the adjustment amount was $105.50.

Paid Date/Amount	This field is divided into two segments. In the left segment of the field, enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient's third party insurance carrier paid or denied the claim. For example, enter 10012015 if the date was October 1, 2015. Enter the amount paid by the other insurance carrier in the right segment of the field, using a decimal point. For example, enter 105.50 if the paid amount was $105.00. A zero (0) amount may be entered. If the third party insurance carrier paid $0.00, you still should complete the Paid Date/Amount field with the date of third party insurance EOB denial and the amount of 0.00.
Carrier Code (Policy Holder)	Select the carrier number for the third party insurance from the drop down list, or enter an appropriate value as specified, or double-click on the data entry portion of the field to add a reference list selection.
Group Number (Policy Holder)	Resource code that identifies the third party insurance carrier. This field is automatically populated after you select or enter a carrier code. *Information* cannot *be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
Group Name (Policy Holder)	Name of the group or business that makes the insurance available to the insured person (this is *not* the third party insurance carrier). This field is automatically populated after you select or enter a Carrier Code. *Information cannot be entered directly into this field. If you need to add or edit* information *in this field, access the Policy Holder Form.*
Last Name (Policy Holder)	Policyholder's last name. This field is automatically populated after you select or enter a carrier code. *Information* cannot *be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
First Name (Policy Holder)	Policyholder's first name. This field is automatically populated after you select or enter a carrier code.

	Information cannot be entered directly into this field. If you need to add or edit information *in this field, access the Policy Holder Form.*

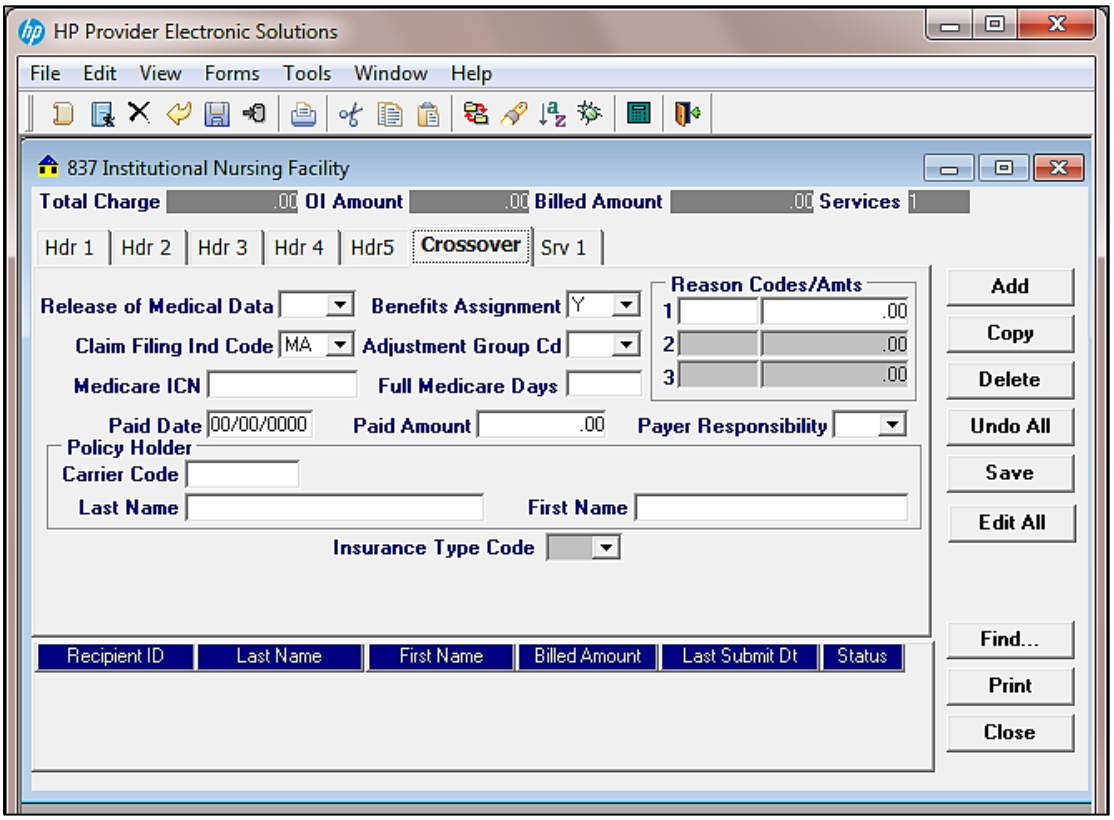
Step 7.1 To add another other insurance line, click Add OI. A new blank service line is added to the screen.

Step 7.2 Click on the new service line, and then enter the other insurance data in the appropriate data fields, as described in this step.

Step 7.3 To copy the data from an existing other insurance line to a new service line, click on the existing service line you want to copy and then click Copy OI. A new service line is added to the screen that has the same data as the existing service line that you previously selected. Edit the data in the new service line by clicking on the line, and then change the appropriate fields.

Step 7.4 To delete an existing other insurance line, click on the service line that you want to delete, then click Delete OI. The selected other insurance line is deleted.

Step 8. Complete Crossover.



The Crossover screen is added to the claim if you selected Y in the Crossover Ind field on the Header 3 screen.

Step 8.1 To access the Crossover screen, click the Crossover tab. The Crossover screen is displayed.

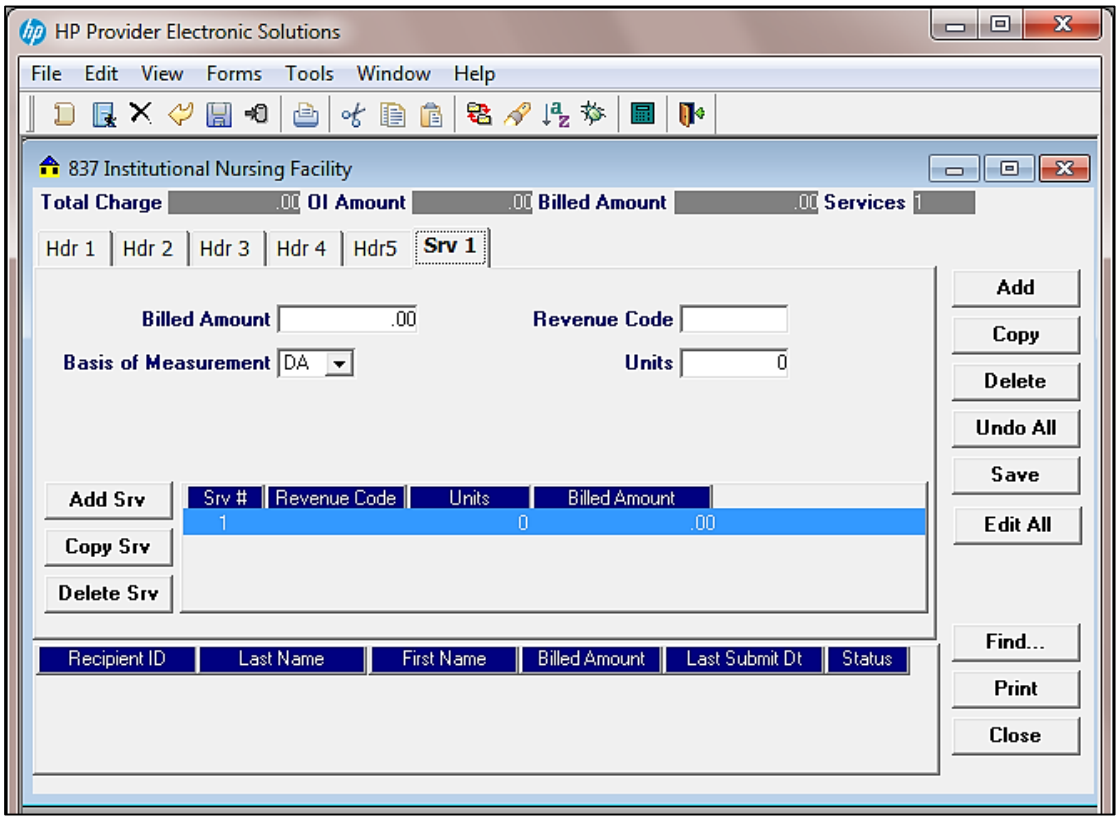
Release of Medical Data	Select the appropriate release code from the drop down list, or enter an appropriate value as specified: Select **I** – Informed Consent to Release Medical Information Select **Y** – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim – Use if the provider has a signed statement on file permitting the release of medical data to other organizations.
Benefits Assignment	Select the appropriate assignment code from the drop down list, or enter an appropriate value as specified: Select **Y —** Yes - if the recipient, or authorized person has authorized that benefits be assigned to the provider. Select **N —** No - if the recipient, or authorized person has not authorized that benefits be assigned to the provider. Select **W** for Not Applicable – Not applicable for this claim.
Claim Filing Indicator Code	Select the appropriate claim code from the drop down list, or enter an appropriate value as specified. The claim code identifies the type of other insurance claim that is being submitted. **MC** – Medicaid **09** – Self-Pay **10** – Central Certification **11** – Other Non-Federal Program **12** – Preferred Provider Organization (PPO) **13** – Point of Sale (POS) **14** – Exclusive Provider Organization (EPO) **15** – Indemnity Insurance **16** – Health Maintenance Organization (HMO) Medicare Risk **AM** – Automotive Medical **BL** – Blue Cross/ Blue Shield **CH** - CHAMPUS **CI** – Commercial Insurance Co. **DS** – Disability **HM** – Health Maintenance Organization **LI** - Liability **LM** – Liability Medical

	MA – Medicare Part A **MB** – Medicare Part B **OF** – Other Federal Program **TV** – Title V **VA** – Veteran Administration Plan **WC** – Worker's Compensation Health Claim **ZZ** – Mutually Defined
Adjustment Group Code	General category of the adjustment being made to the claim. Select the adjustment group code from the drop down list, or enter an appropriate value as specified. This field can be left blank if no reason code is being used. **CO** – Contractual Obligations **CR** – Correction and Reversals+ **OA** – Other Adjustments **PI** – Payer Initiated Reductions **PR** – Patient Responsibility
Reason Codes/Amounts	Select the appropriate Reason Code from the drop down list or enter an appropriate value as specified, if applicable. **1** – Deductible Amount **118**-ESRD Network Support Adjustment **119** – Benefit Maximum for this time period has been reached **2** – Coinsurance Amount **23** – Payment adjusted because charges were paid by another payer **3** – Copayment Amount **35** – Lifetime Benefits Maximum has been reached **45 -** Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement **50** – Non-covered services
Medicare ICN	Enter the Medicare ICN found on the Medicare EOMB for the service being billed.
Full Medicare Days	Enter the total number of days during the service month that were fully covered by Medicare. **(Days 1-20 of the resident's stay)**
Paid Date	Enter the 2-digit month, 2-digit day, and 4-digit year the Medicare coinsurance was paid. This information can be found on the Medicare EOMB.

Paid Amount	Enter the total amount that Medicare paid for the **coinsurance** days during the service month, using a decimal point. This information can be found on the Medicare EOMB. A zero (0) amount may be entered.
Payer Responsibility	Level of payer responsibility for the resident's other insurance. Select the appropriate code from the drop down list, or enter an appropriate value as specified: **P** – Payer 1 **S** – Payer 2 **T** – Payer 3 **A** – Payer 4 **B** – Payer 5 **C** – Payer 6 **D** – Payer 7 **E** – Payer 8 **F** – Payer 9 **G** – Payer 10 **H** – Payer 11 **U** – Unknown
Carrier Code (Policy Holder)	Select a carrier code from the drop down list, or enter an appropriate value as specified. The carrier code identifies the recipient's third party insurance carrier.
Last Name (Policy Holder)	Policyholder's last name. This field is automatically populated after you select a group number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
First Name (Policy Holder)	Policyholder's first name. This field is automatically populated after you select a group number. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
Insurance Type Code	The window is only active if the payer is Medicare with Claim filing code of MB and the Payer Responsibility is not P (Primary) Select the appropriate value from the dropdown box that identifies the type of insurance listed, or enter an appropriate value as

	specified. (Insurance Type Code is a 'Do Not Use' field in the 837 Institutional Implementation Guide) **12** – Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan **13** –Medicare Secondary, End-Stage Renal Disease in the Mandated Coordination Period with an Employer's Group Health Plan **14** – Medicare Secondary, No-fault Insurance including Auto is Primary **15** – Medicare Secondary, Worker's Compensation **16** – Medicare Secondary Public Health Service (PHS) or Other Federal Agency **41** – Medicare Secondary Black Lung **42** – Medicare Secondary Veteran's Administration **43** – Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) **47** – Medicare Secondary, Other Liability Insurance is Primary

Step 9. Complete Service 1.



Billed Amount	Enter the billed amount for the revenue code indicated.

	ICF/MR and ICF/ORC facilities should use the full per diem rate for up to 15 consecutive Hospital Days.
Revenue Code	Specific accommodation or ancillary service. Select the revenue code from the drop down list, or enter an appropriate value as specified: **0100** – Indicates the number of facility days. **0183** – Indicates the number of leave days. **0185** – Indicates the number of hospital days. When billing for co-insurance days, and no other billable days exist, refer to the *Frequently Asked Questions* in Appendix A.
Basis of Measurement	Select the **DA** (days institutional) basis code from the drop down list or enter an appropriate value as specified. The basis code identifies the units in which a value is being expressed, or the manner in which a measurement was taken. **DA** – Days (Institutional) **MJ** – Minutes (Professional) **UN** – Unit (Institutional and Professional)
Units	Enter the number of units provided to the resident for the revenue code being billed. For example, enter 1, if one unit was provided to the recipient. Zero (0) units are an acceptable entry.

Note: Other Provider fields are not used in the 837 Institutional Long Term Care claim. Leave these fields blank.

Step 9.1 To add another service line, click Add Srv. A new blank service line is added to the screen.

Step 9.2 Click on the new service line, and then enter the service data in the appropriate fields, as described in this step.

Step 9.3 To copy the data from an existing service line to a new service line, click on the existing service line you want to copy, then click Copy Srv. A new service line is added to the screen that has the same data as the existing service line that you previously selected. Edit the data in the new service line by clicking on the new line and changing the appropriate fields.

Step 9.4 To delete an existing service line, click on the service line that you want to delete, and then click Delete Srv. The selected service line is deleted.

Step 10. Click Save to save the information in the institutional nursing form.

Step 11. Click Add to start another institutional nursing claim.

9.7 Complete an 837 Institutional Outpatient Form

The 837 Institutional Outpatient Form is used to create claims for outpatient services normally billed on a UB-04 form. The 837 Institutional Outpatient Form is divided into ten screens. Each screen contains the following claim data:

Hdr 1	Accesses the screen that contains the provider and recipient information.
Hdr 2	Accesses the screen that contains the ICD Version, diagnosis, and condition code information.
Hdr 3	Accesses the screen that contains information about the attending, operating and rendering provider.
Hdr 4	Access the screen that contains the referring Provider, emergency indicator patient paid, value codes and contract information.
Pat	Accesses the screen that contains patient information used for newborns, and is accessed by selecting **Y** in the Newborn Indicator on Hdr 3.
O/I	Accesses the screen that contains information about other insurance coverage, It is accessed by selecting **Y** in the OI Indicator on Hdr 3.
Crossover	Accesses the screen that contains information about Medicare coverage. It is accessed by selecting **Y** in the Crossover Indicator on Hdr 3.
Srv 1	Accesses the screen that contains service information.
Srv 2	Accesses the screen that contains additional attending and operating provider information.
Srv 3	Accesses the screen that contains service adjustment indicator.
Srv Adj	Accesses the screen that contains service adjustment information.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

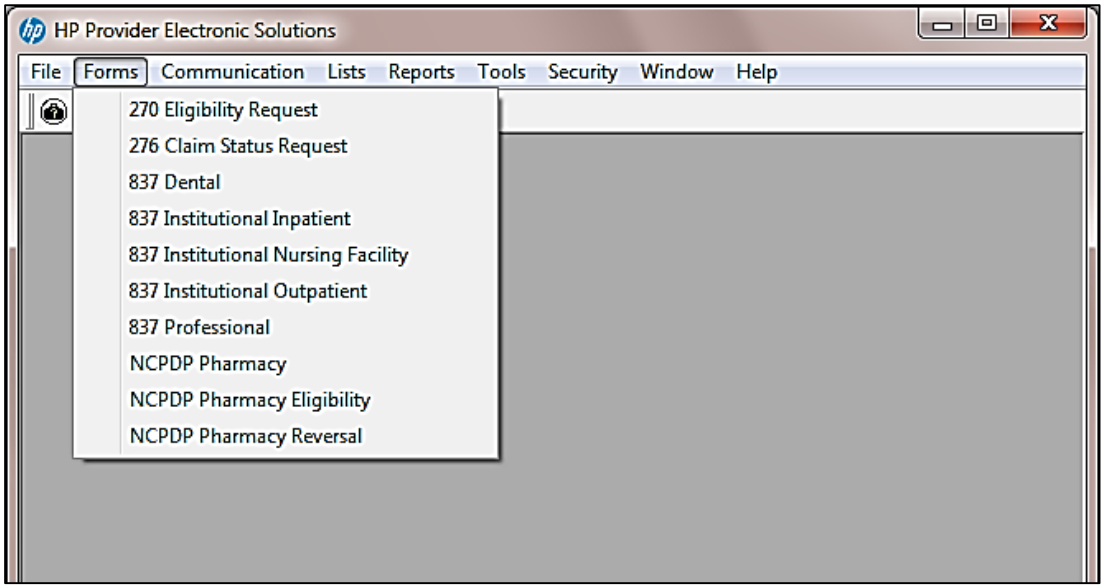
To create an Institutional Outpatient Claim, perform the following steps:

Step 1. From the Provider Electronic Solutions software main screen, access the 837 Institutional Outpatient Form in one of two ways:

Click (837 Institutional Outpatient Shortcut icon) on the Toolbar

or

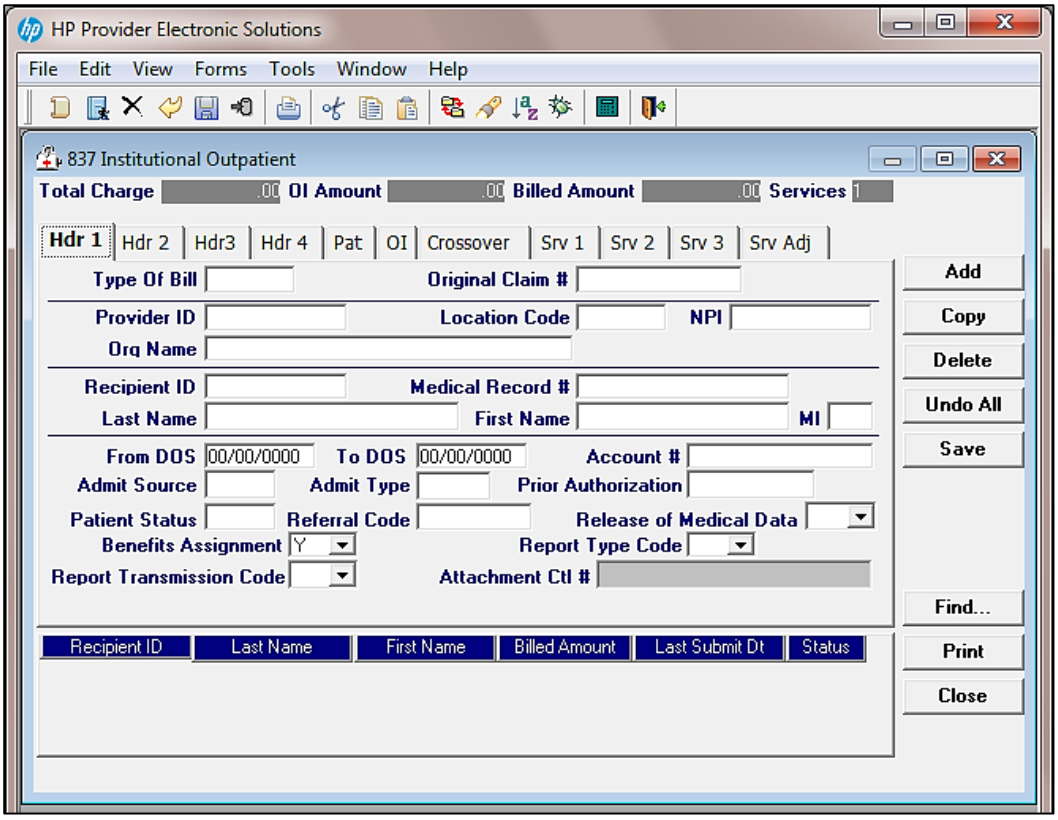
Select the 837 Institutional Outpatient Option from the Forms drop down menu:



Note: When you choose a selection from a drop down list, many of the fields are populated.

For additional information on reference lists, refer to the List options in section 6.3.4, of this manual.

Step 2. Complete Header 1.



Type of Bill	Select a type of bill code from the drop down list, or enter the appropriate value based on your facility and bill type: Outpatient Hospitals use a type of bill code that begins with **13.** When billing for a hospital special treatment room, use a type of bill code that begins with **14.** Select the last digit of the type of bill code based on the definitions listed below: **0** – Non Payment/Zero Claim **1** – Admit Through Discharge Claim **7** – Replacement of a Prior Claim **8** – Void/Cancel of Prior Claim
Original Claim #	Enter the 13-digit original ICN. When submitting a previously rejected claim, or a claim adjustment that was adjudicated **prior** to the implementation of PROMISe™, enter the 10-digit CRN followed by the 2-digit line number, as printed on the RA statement.
Provider ID	Select the 9-digit MPI number of the provider for whom the claim will be paid from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. If assigning payment to a group, select the 9-digit group MPI number.
Location Code	Field is automatically populated with the location code associated with the MPI number selected in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Org Name	Provider's organization name or the group name. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Recipient ID	The recipient's 10-digit recipient number. For additional information on the Recipient ID field, refer to *Recipient Reference List* in section 8.3 of this manual.

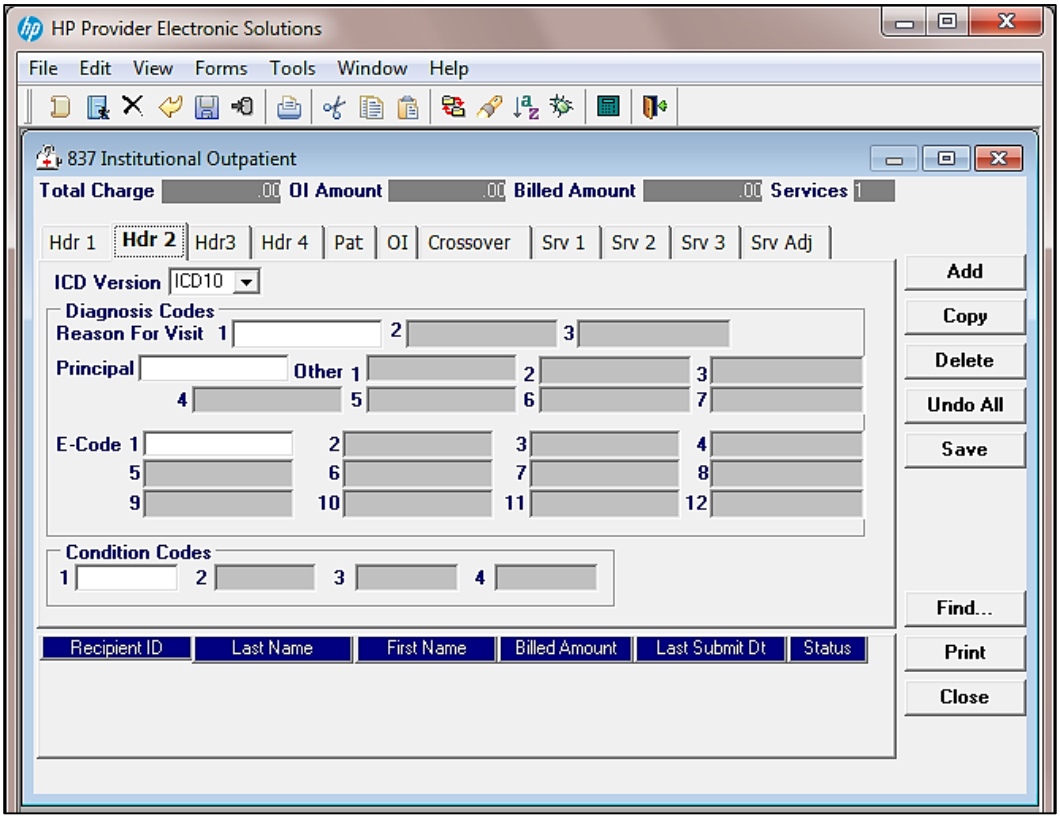
	Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
Medical Record #	Medical record number assigned to the recipient by your facility. This field is automatically populated after you select or enter a recipient ID. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
Last Name	Recipient's last name. This field is automatically populated after you select or enter a recipient ID. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
First Name	Recipient's first name. This field is automatically populated after you select or enter a recipient ID. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
Middle Initial	Recipient's middle initial. This field is automatically populated after you select or enter a recipient ID. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
From DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient first received service under this claim. For example, enter 10012015 if the date was October 1st, 2015. If the same service was provided on a single day, enter the date of service in both the From DOS and To DOS fields.
To DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient last received service under this claim. For example, enter 10012015 if the date was October 1, 2015.
Account Number	Provider's own reference number for the recipient. Enter the 30-character account number assigned to the recipient by your facility. This data appears in the first column of the RA statement when the claim is adjudicated. A unique account number is required for each claim submitted to be able to obtain claim status information. If the same account number is used for each claim submitted when a claim status request is sent, the claim status is reported on **all** claims with that account number.

Admit Source	Enter the code that identifies the source of admission to the facility, or choose the appropriate code from the field's preloaded drop down list, or enter an appropriate value as specified: **1** – Physician Referral **2** – Clinic Referral **3** – HMO Referral **4** – Transfer from a Hospital **5** – Transfer from a Skilled Nursing Facility **6** – Transfer from Another Healthcare Facility **7** – Emergency Room **8** – Court/Law **9** – Information Not Available **A** – Transfer from a Rural Primary Care Hospital
Admit Type	Admit Type Code – Enter the code that identifies the type of admission to the facility or choose the appropriate code from the field's pull-down list, or enter an appropriate value as specified: **1** – Emergency Admission. An emergency admission is defined as the patient's condition requires immediate medical attention and any time delay would be harmful to the patient. **2** – Urgent Admission. An urgent admission is defined as the patient's condition, while not immediately essential, should have medical attention provided very early to prevent possible loss or impairment of life, limb or body function. **3** – Elective Admission. An elective admission is defined as a scheduled or planned admissions. **4** – Newborn. Admission of a newborn baby. **5** – Trauma Center Admission to a trauma center.
Prior Authorization	Enter the 10-digit CHR/DRG/PSR admission certification number. Enter the 10-digit Prior Authorization number if the service requires and has received a prior authorization. Enter the 10-digit PSR number if admission to an acute care hospital, a hospital SPU, or an ambulatory surgical center (ASC) is elective. Enter the 10-digit Admission Certification number for urgent or emergency admission to an acute care hospital, SPU, ASC, or specialty hospital. Enter the 10-digit authorization number for approved 1150 Administrative Waiver Services.

Patient Status	Recipient's status on the last date of service billed on this claim. Enter the appropriate 2-digit status code or select the status code from the drop down list or enter the appropriate value, or enter an appropriate value as specified: **01** – Dischrgd to home or self-care (routine discharge) **02** – Dischrgd/trnsfrrd to another hospital for inpatient care **03** – Dischrgd/transfrrd to skilled nursing facility **04** – Dischrgd/transfrrd to an intermediate care facility **05** – Dischrgd/transfrrd to another type of institution for inpatient care **07** – Left against medical advice or discontinued care **20** – Expired **30** – Still a patient	
Referral Code	Enter the referral number provided by a primary care case manager.	
Release of Medical Data	Select the appropriate release code from the drop down list, or enter an appropriate value as specified: **I** – Informed Consent to release Medical Information - Informed consent to release medical information for conditions or diagnosis regulated by Federal statutes. **Y** – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim - Provider has a signed statement on file that permits the release of medical data to other organizations.	
Benefits Assignment	Select the appropriate assignment code from the drop down list, or enter an appropriate value as specified: **Y** – Recipient or authorized person has authorized that benefits be assigned to the provider. **N** – Recipient or authorized person has not authorized that benefits be assigned to the provider. **W** – Not Applicable	
Report Type Code	Enter the appropriate code for the type of attachment submitted or enter an appropriate value as specified:	
	AS – Admission Summary **B2** – Prescription **B3** – Physician Order **B4** – Referral Form **CT** – Certification	**NN** – Nursing Notes **OB** – Operative Notes **OZ** – Support Data for Claim **PN** – Physical Therapy Notes

	DA – Dental Models **DG** – Diagnostic Report **DS** – Discharge Summary **EB** – Explanation of Benefits **MT** - Models	**PO** – Prosthetics or Orthotics Notes **PZ** – Physical Therapy Certification **RB** – Radiology Films **RR** – Radiology Reports **RT** – Report of Tests and Analysis
Report Transmission Code	Enter the appropriate code for the method of attachment transmission. **AA** – Available by request at Provider site **BM** – By Mail **EL** – Electronically Only **EM** – E-Mail **FT** – File Transfer **FX** – By Fax	
Attachment Control Number	Enter the (up to) 10-digit attachment control number obtained from the PROMISe™ web site. This number is used when a paper attachment is required by MA to cross reference the paper attachment with the electronic claim. This number must also be written on the cover letter sent to MA.	

Step 3. Complete Header 2.

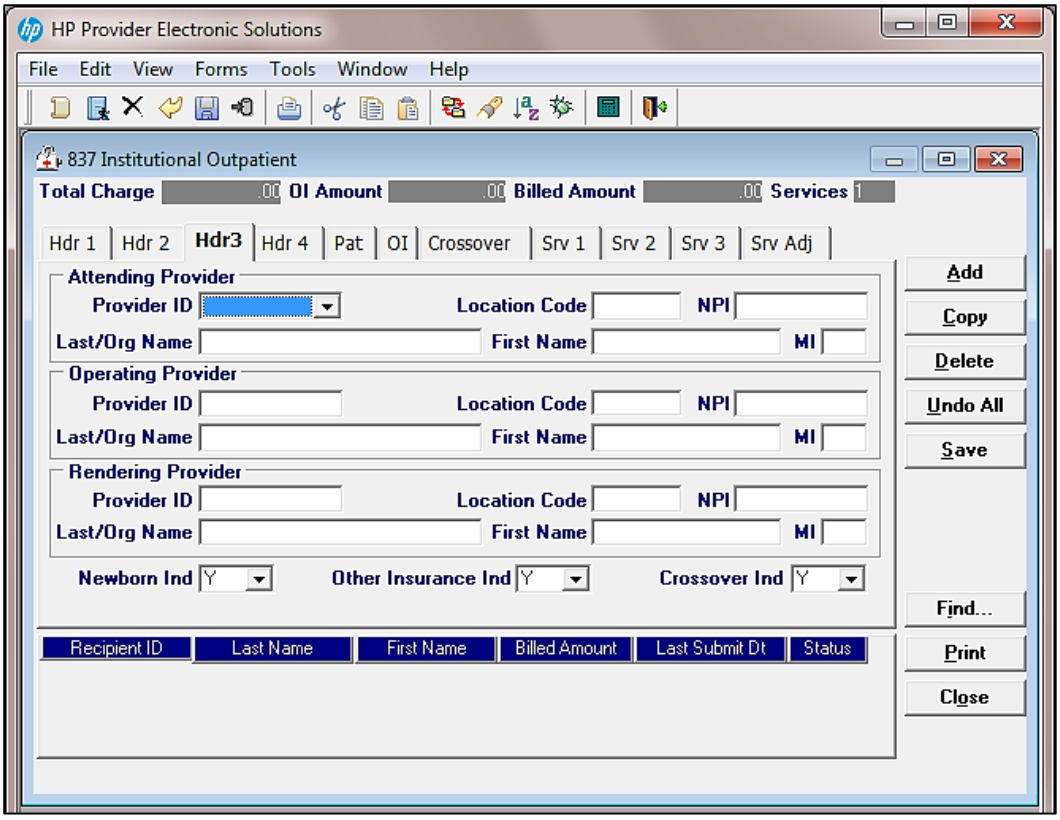

HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Outpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr3 Hdr 4 Pat OI Crossover Srv 1 Srv 2 Srv 3 Srv Adj
ICD Version ICD10
Diagnosis Codes
Reason For Visit 1 2 3
Principal Other 1 2 3
4 5 6 7
E-Code 1 2 3 4
5 6 7 8
9 10 11 12
Condition Codes
1 2 3 4
Add
Copy
Delete
Undo All
Save
Find...
Print
Close
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status

ICD Version	Use the ICD 9/ICD10 Version for the code being submitted.
Reason for Visit (Diagnosis Codes)	Most specific ICD-9-CM/ICD-10-CM/PCS diagnosis code that indicates what caused the recipient to contact the facility. Select the Reason for Visit diagnosis code from the drop down list, or enter an appropriate value as specified.
Principal (Diagnosis Codes)	Primary diagnosis code is the most specific ICD-9-CM/ICD-10-CM/PCS diagnosis code that relates to a recipient's stay. Select the principal diagnosis code from the drop down list, or enter an appropriate value as specified.
Other (Diagnosis Codes)	Indicate additional diagnoses that relate to the recipient's condition.
E-Code (Diagnosis Codes)	Diagnosis code that describes the external cause of the recipient's injury. Select the external diagnosis code from the drop down list, or enter an appropriate value as specified.

Condition Codes	Each Condition Code field identifies a condition relating to the invoice that may affect payer processing. Enter the appropriate 2-character condition code, or select the appropriate code from the drop down list, or enter an appropriate value as specified: **02** – Condition is Employment Related **03** – Patient Covered by Insurance Not Reflected Here **05** – Lien Has Been Filed **60** – Day Outlier **77** – Payment was accepted – payment in full **A1** – EPSDT/CHAP **A3** – Special Federal Funding **A4** – Family Planning **A7** – Induced Abortion – Danger to Life **A8** – Induced Abortion – Victim Rape/Incest **AI** – Sterilization **B3** – Pregnancy Indicator **DR** – Disaster Related

If the provider is a qualified small business, enter QSB in the Billing Note field. You may enter more than one code, if applicable. Example: VC09QSB for a claim filed by a qualified small business dental provider for services rendered to a pregnant woman.

Step 4. Complete Header 3.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Outpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr3 Hdr 4 Pat OI Crossover Srv 1 Srv 2 Srv 3 Srv Adj
Attending Provider
Provider ID Location Code NPI
Last/Org Name First Name MI
Operating Provider
Provider ID Location Code NPI
Last/Org Name First Name MI
Rendering Provider
Provider ID Location Code NPI
Last/Org Name First Name MI
Newborn Ind Y Other Insurance Ind Y Crossover Ind Y
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

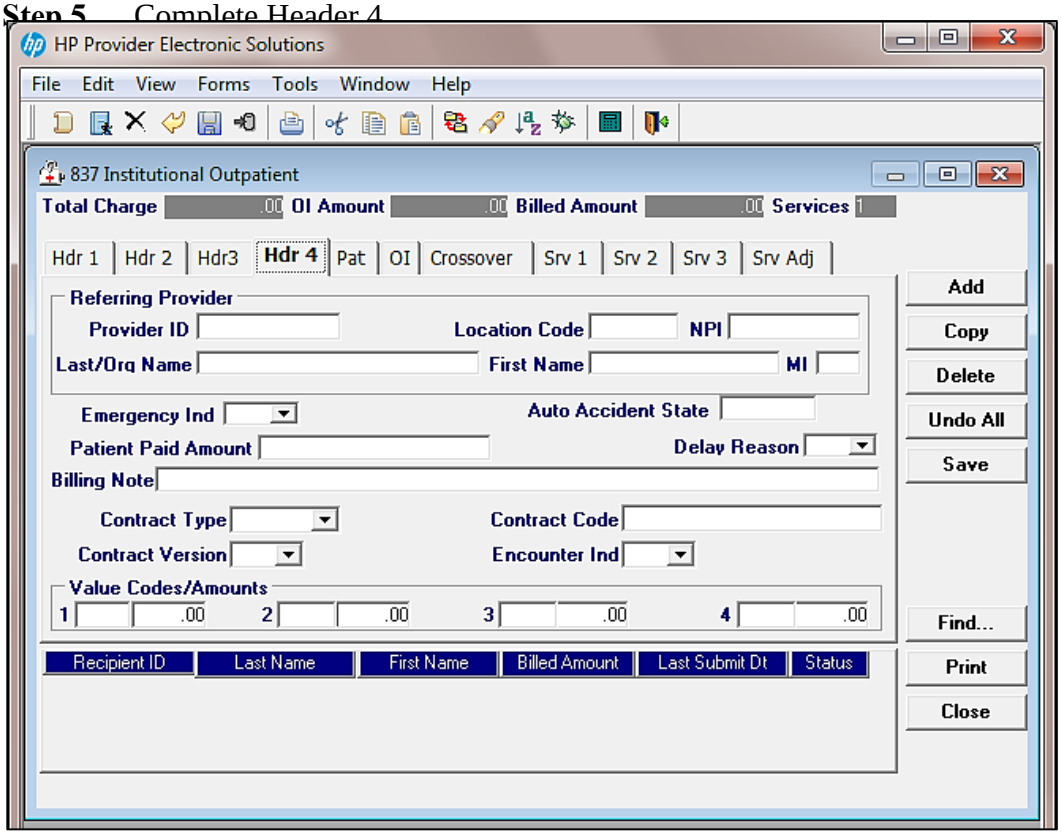
Provider ID (Attending)	Enter the 8- or 9-digit medical license number or 9-digit MPI number for the attending physician in this field.
Location Code (Attending)	The 4-digit location code associated with the attending MPI number. This field is automatically populated when a value is selected in the Attending Provider ID field. *Information cannot be* entered *directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Attending)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Attending)	Last name or organization name for the attending provider. This field is automatically populated when a value is selected in the Attending Provider ID field. *Information cannot* be *entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*

First Name (Attending)	First name for the attending provider. This field is automatically populated when a value is selected in the Attending Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit* information *in this field, access the Provider Form.*
MI (Attending)	Middle initial for the attending provider ID. This field is automatically populated when a value is selected in the Attending Provider ID field. *Information* cannot *be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Provider ID (Operating)	Enter the 8- or 9-digit medical license number or 9-digit MPI number for the physician performing a surgical procedure in this field.
NPI (Operating)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Operating)	Last name or organization name for the operating provider. This field is automatically populated when a value is selected in the Operating Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Operating)	First name for the operating provider. This field is automatically populated when a value is selected in the Operating Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
MI (Operating)	Middle initial for the operating provider ID. This field is automatically populated when a value is selected in the Operating Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Provider ID (Rendering Provider)	Provider who rendered the service. Select the 9-digit MPI number for the provider of service(s) from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. Complete this field if a group's MA ID was entered on

	Header 1 (indicates that a group receives the payment, instead of an individual provider).
Location Code (Rendering Provider)	Rendering provider's 4-digit service facility location number for the MPI number selected in the Referring Provider ID field. This field is automatically populated with the correct information after an MPI number is selected in the Rendering Provider ID field. *Information cannot be* entered *directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Rendering Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Rendering Provider)	Rendering provider's last name or organization name. This field is automatically populated with the correct information after an MPI number is selected in the Rendering Provider ID field. *Information cannot be* entered *directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Rendering Provider)	Rendering provider's first name. This field is automatically populated with the correct information after an MPI number is selected in the Rendering Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
MI (Rendering Provider)	Rendering provider's middle initial. This field is automatically populated with the correct information after an MPI number is selected in the Rendering Provider ID field. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
Newborn Ind	Indicator that the claim is being submitted for recipient's newborn. Select the appropriate response from the drop down list: **Y –** Yes-Recipient is a newborn **N –** No-Recipient is not a newborn
Other Insurance Indicator	Used to activate the O/I screen, which is used to record a recipient's other insurance information. Select the other insurance code from the drop down list, or enter an appropriate value as specified: **Y –** Yes-Recipient has other insurance **N –** No-Recipient **does** not have other insurance

Crossover Indicator	Used to activate the Crossover screen, which is used to record a recipient's Medicare information. Select the crossover code from the drop down list, or enter the appropriate value, as described below: **Y –** Yes-Recipient has Medicare **N –** No-Recipient does not h**a**ve Medicare

Step 5 Complete Header 4


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Outpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr3 Hdr 4 Pat OI Crossover Srv 1 Srv 2 Srv 3 Srv Adj
Referring Provider
Provider ID Location Code NPI
Last/Org Name First Name MI
Emergency Ind Auto Accident State
Patient Paid Amount Delay Reason
Billing Note
Contract Type Contract Code
Contract Version Encounter Ind
Value Codes/Amounts
1 .00 2 .00 3 .00 4 .00
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

Provider ID (Referring Provider)	Enter the 8- or 9- digit medical license number or MPI number for the physician who referred the recipient for the service performed, or double-click in the data entry portion of the field to add a reference list selection. **Note**: For Access Plus Referred Services, select the 13-digit MAID number for the referring provider from the field's pull down list.
Location Code (Referring Provider)	Referring provider's 4-digit service facility location number for the MPI number selected in the Referring Provider ID field. This field is automatically populated with the correct information after an MPI number is selected in the Referring Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Referring Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.

Last/Org Name (Referring Provider)	Referring provider's last name or organization name. This field is automatically populated with the correct information after an MPI number is selected in the Referring Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Referring Provider)	Referring provider's first name. This field is automatically populated with the correct information after an MPI number is selected in the Referring Provider ID field. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
Middle Initial (Referring Provider)	Referring provider's middle initial. This field is automatically populated with the correct information after an MPI number is selected in the Referring Provider ID field. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
Emergency Indicator	Select the appropriate Emergency Indicator code from the drop down list or enter an appropriate value as specified. Select **3**, if the service provided was in response to an emergency
Auto Accident State	Enter the two-letter abbreviation for the state where the accident occurred. For example, enter **PA** for Pennsylvania.
Patient Paid Amount	Enter the amount the recipient has paid towards his/her medical bills as determined by the local CAO. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM. For example, enter 25.50 if the amount was $25.50. Use a decimal point. **Do not enter copay in this field.**

<table>
<tr><td>Delay Reason</td><td colspan="2">Select the appropriate code to indicate why a claim is being submitted outside of the 180-day initial submission window. This field is optional:</td></tr>
<tr><td></td><td>1 – Proof of Eligibility Unknown or Unavailable
2 – Litigation
3 – Authorization Delays
4 – Delay in Certifying Provider
5 – Delay in Supplying Billing Forms
6 – Delay in Delivery of Custom-Made Appliances</td><td>7 – Third Party Processing Delay
8 – Delay in Eligibility Determination
9 – Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10 – Administration Delay in the Prior Authorization Process
11 - Other</td></tr>
<tr><td>Billing Note</td><td colspan="2">Used to record visit codes necessary to adjudicate MA claims. This field is optional:

If the provider is a qualified small business, enter QSB in the Billing Note field. You may enter more than one code, if applicable. Example: VC09QSB for a claim filed by a qualified small business dental provider for services rendered to a pregnant woman.</td></tr>
</table>

If the visit code is…	Which means …	Then enter…	
09	Services rendered to a pregnant woman (Dental only)	**VC09**	
10	Services rendered to an LTC or a state mental hospital resident	**VC10**	
11	Provider attempted but was unsuccessful in collecting a co-payment	**VC11**	
QSB	If the provider is a qualified small business.	**QSB**	
EPSDT	If the claim involved EPSDT referral information any or all of the following that apply must be entered.		

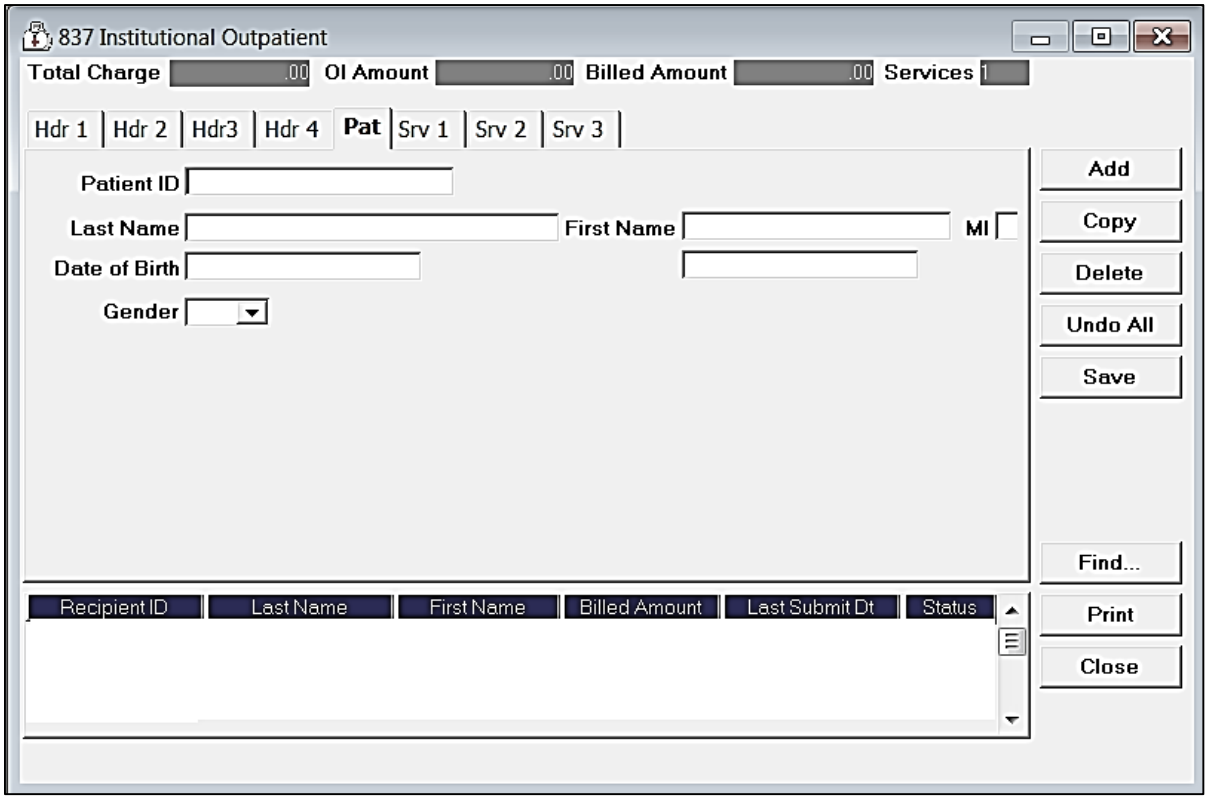
		EPSDT – Dental Referral	**YD**	
		EPSDT – Vision Referral	**YV**	
		EPSDT – Hearing Referral	**YH**	
		EPSDT – Medical Referral	**YM**	
		EPSDT – Behavioral Health Referral	**YB**	
		EPSDT – Other Referral	**YO**	

If the provider is a qualified small business, enter QSB in the Billing Note field. You may enter more than one code, if applicable. Example: VC09QSB for a claim filed by a qualified small business dental provider for services rendered to a pregnant woman.

Contract Type	The indicator represents the contract between the provider and the managed care or sub-capitation subcontractor. Choose a value from the drop-down list. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Code	The contract number between the provider and the managed care or sub-capitation subcontractor. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Version	If submitting a managed care claim where there is a sub-capitation arrangement, choose the contract version from the pull-down list. The contract version is the month of the contract that was in force at the time of the service. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Encounter Ind	Select the encounter indicator from the field's pull down list. o Select RP, if the claim is an encounter record (Consolidated Community Reporting Use Only)

	○ Select CH, if the claim is a Fee for Service claim. The default value for this field is CH.
Value Codes/Amounts, Fields 1-4	Enter the National Uniform Billing Committee (NUBC) code that relates amounts or values to identify data elements necessary to process a form as qualified by the payer organization. These values are preloaded and are HIPAA-compliant. If any changes or modifications need to be made to these values, you will be notified by DHS or HP Enterprise Services. Select the appropriate value from the drop down list or enter an appropriate value as specified.**06** – Medicare Blood Deductible **06** – Medicare Blood Deductible **14** – No Fault Auto/Other **15** – Workman's Compensation **16** – PHS or Other Federal Agency **25** – Drug Deduction **31** – Patient Liability Amount **34** – Offset to Patient Payment Amount - Other Medical Expense **35** – Offset to Patient payment Amount – Health Insurance Premium **38** – Medicare Blood Deductible Pints Furnished **39** - Medicare Blood Deductible Pints Replaced **47** – Any Liability Insurance **66** – Patient Paid Amount In the right segment of this field, enter the dollar amount for each code, using a decimal point.

Step 6. Complete PAT.

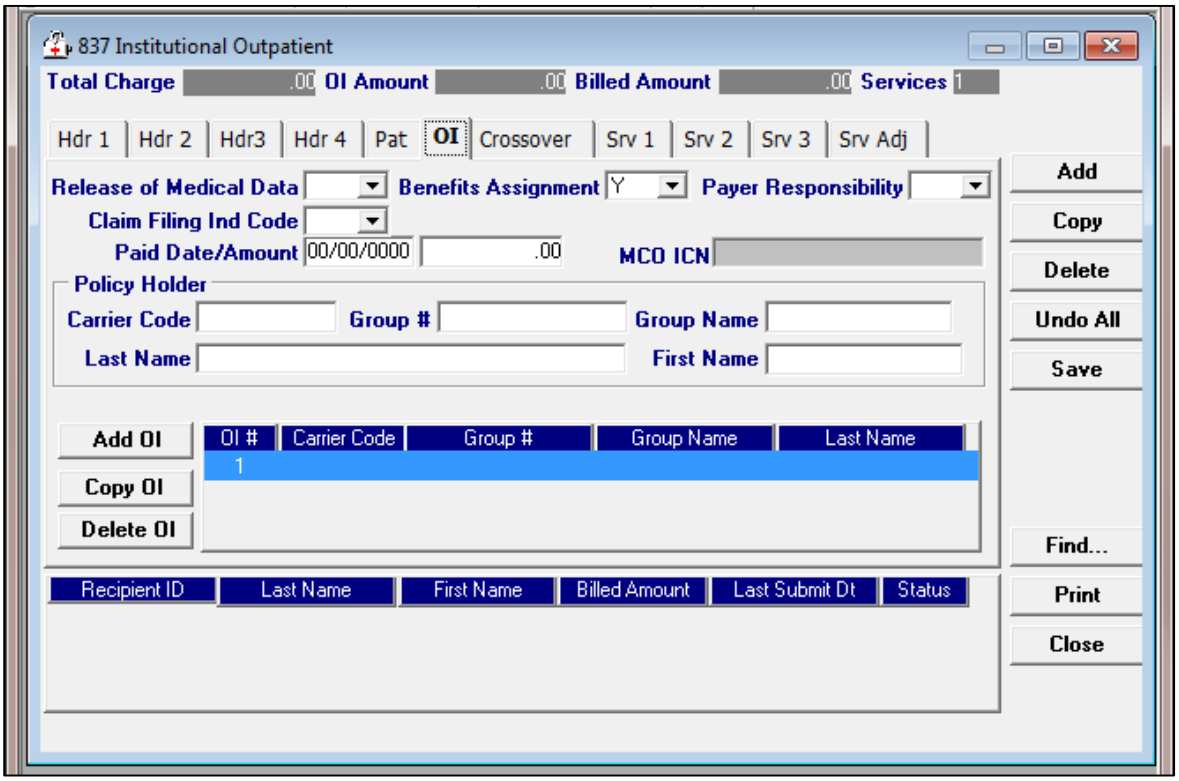


Step 6.1 To access the Pat tab, select **Y** in the Newborn Indicator field. Access this tab when the claim is for a newborn or maternity care.

Patient ID	Enter the Recipient ID of the newborn. If the newborn recipient does not have an ID number, leave this field blank. When the claim is submitted this field automatically populates with the mother's recipient ID number.
Last Name	Enter the last name of the newborn.
First Name	Enter the first name of the newborn.
MI	Enter the middle initial of the newborn.
Date of Birth	Enter the date of birth of the newborn. The format is the 2-digit month, 2-digit day, and 4-digit year.

Gender	Select the appropriate gender from the drop down box, or enter the appropriate value. **F** – Female **M** – Male **U** – Unknown

Step 7. Complete Other Insurance.



Step 7.1 To access the OI tab, select **Y** in the Other Insurance field. Access this tab when the recipient has Other Insurance information.

Release of Medical Data	Select the release code from the drop down list, or enter an appropriate value as specified: Select **I** – Informed Consent to Release Medical Information conditions or diagnosis regulated by federal statutes. Select **Y** – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a claim. If the provider has a signed statement on file permitting the release of medical data to other organizations.

Benefits Assignment	Select the assignment code from the drop down list, or enter an appropriate value as specified: **Y** – Yes-Recipient or authorized person has authorized that benefits be assigned to the provider. **N** – No-Recipient or authorized person has not authorized that benefits be assigned to the provider. **W** – for Not Applicable – Not applicable for this claim.	
Payer Responsibility	Payer responsibility for the recipient's other insurance. Select the appropriate code from the drop down list, or enter an appropriate value as specified: **P** – Payer 1 **S** – Payer 2 **T** – Payer 3 **A** – Payer 4 **B** – Payer 5 **C** – Payer 6 **D** – Payer 7 **E** – Payer 8 **F** – Payer 9 **G** – Payer 10 **H** – Payer 11 **U** – Unknown	
Claim Filing Indicator Code	Select the appropriate claim code from the drop down list, or enter an appropriate value as specified. The claim code identifies the type of other insurance claim that is being submitted.	
	MC – Medicaid **11** – Other Non – Federal Program **12** – Preferred Provider Organization (PPO) **13** – Point of Sale (POS) **14** – Exclusive Provider Organization (EOP) **15** – Indemnity Insurance **16** – Health Maintenance Organization (HMO) Medicare Risk **17** – Dental Maintenance Organization	**CI** – Commercial Insurance Co. **DS** – Disability **FI** – Federal Employees Program **HM** – Health Maintenance Organization **LM** – Liability Medical **MA** – Medicare Part A **MB** – Medicare Part B **OF** – Other Federal Program **TV** – Title V

	AM – Automotive Medical **BL** – Blue Cross/Blue Shield **CH** – CHAMPUS	**VA** – Veteran Administration Plan **WC** – Workers Compensation Health Claim **ZZ** – Mutually Defined
Paid Date/Amount	Enter the date on which the other insurance company paid against the claim. Enter the date in a 2-digit month, 2-digit date, and 4-digit year format. Enter the amount paid by the Other Insurance carrier. An amount of zero (0) may be entered. Negative amounts are not allowed on 837 claims.	
MCO ICN	The MCO ICN field contains the internal claim number assigned to the claim when the managed care organization processed the claim from a provider. Consolidated Community Reporting for OMHSAS (CCR) submitters must enter a MCO ICN. **Note:** The MCO ICN field is activated when "RP" is indicated on Hdr 2 AND has a payer on the OI tab with Claim Filing Indicator code "HM". Without these conditions being met, the MCO ICN field will remain disabled.	
Carrier Code (Policy Holder)	Select the carrier code associated with the other insurance coverage from the drop down list.	
Group Number (Policy Holder)	Group number associated with the other insurance coverage. This field is automatically populated when a carrier code is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*	
Group Name (Policy Holder)	Group name associated with the other insurance coverage. This field is automatically populated when a carrier code is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*	
Last Name (Policy Holder)	Last name of the person who carries the other insurance policy. This field is automatically populated when a carrier code is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*	

First Name (Policy Holder)	First name of the person who carries the other insurance policy. This field is automatically populated when a carrier code is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*

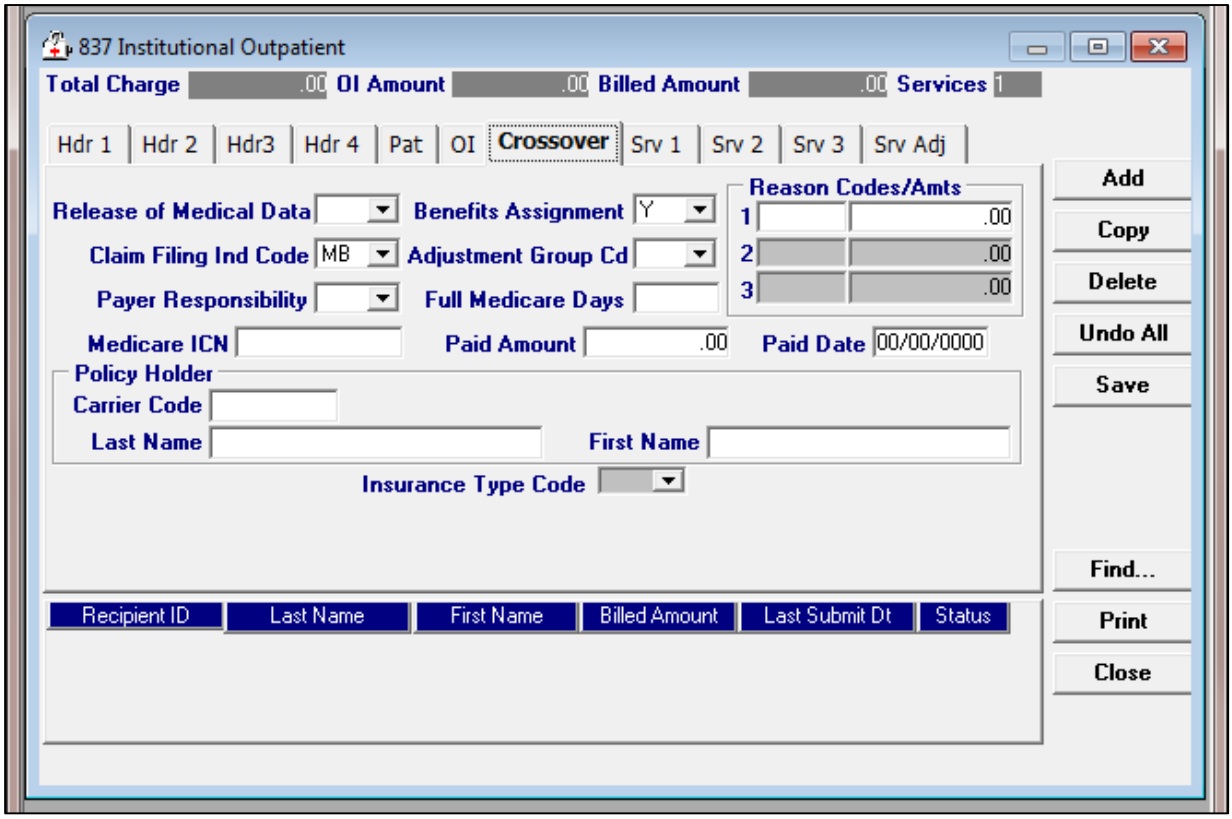
Step 7.2 To add another insurance line, click Add OI. A new blank service line is added to the screen.

Step 7.3 Click on the new service line, and then enter the other insurance data in the appropriate data fields.

Step 7.4 To copy the data from an existing other insurance line to a new service line, click on the existing service line you want to copy, and then click Copy OI A new blank service line is added to the screen that has the same data as the previously selected line. Edit the data in the new service line by clicking on the new line, then make changes to the appropriate fields.

Step 7.5 To delete an existing other insurance line, click on the service line you want to delete, and then click Delete OI. The selected service line is deleted.

Step 8. Complete Crossover.



Step 8.1 To access the Crossover tab, select **Y** in the Crossover Ind field on Header 3.

Release of Medical Data	Select the release code from the drop down list, or enter an appropriate value as specified: Select **I** – Select **I** – Informed Consent to Release Medical Information-Informed consent to release medical information for conditions or diagnosis regulated by federal statutes. Select **Y** – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim – Use if the provider has a signed statement on file permitting the release of medical data to other organizations.
Benefits Assignment	Select the assignment code from the drop down list or enter an appropriate value as specified: **Y** – The recipient or authorized person has authorized that benefits be assigned to the provider. **N** – The recipient or authorized person has not authorized that benefits be assigned to the provider. **W** – for Not Applicable – Not applicable for this claim.

<table>
<tr><td>Reason Codes/Amts</td><td colspan="2">There are three Reason Code/Amount fields. Each field is divided into two segments.

In the left segment of the field, select the appropriate reason code from the segment’s drop down list, or enter an appropriate value as specified. The reason code identifies the reason the adjustment is being made to the claim line:

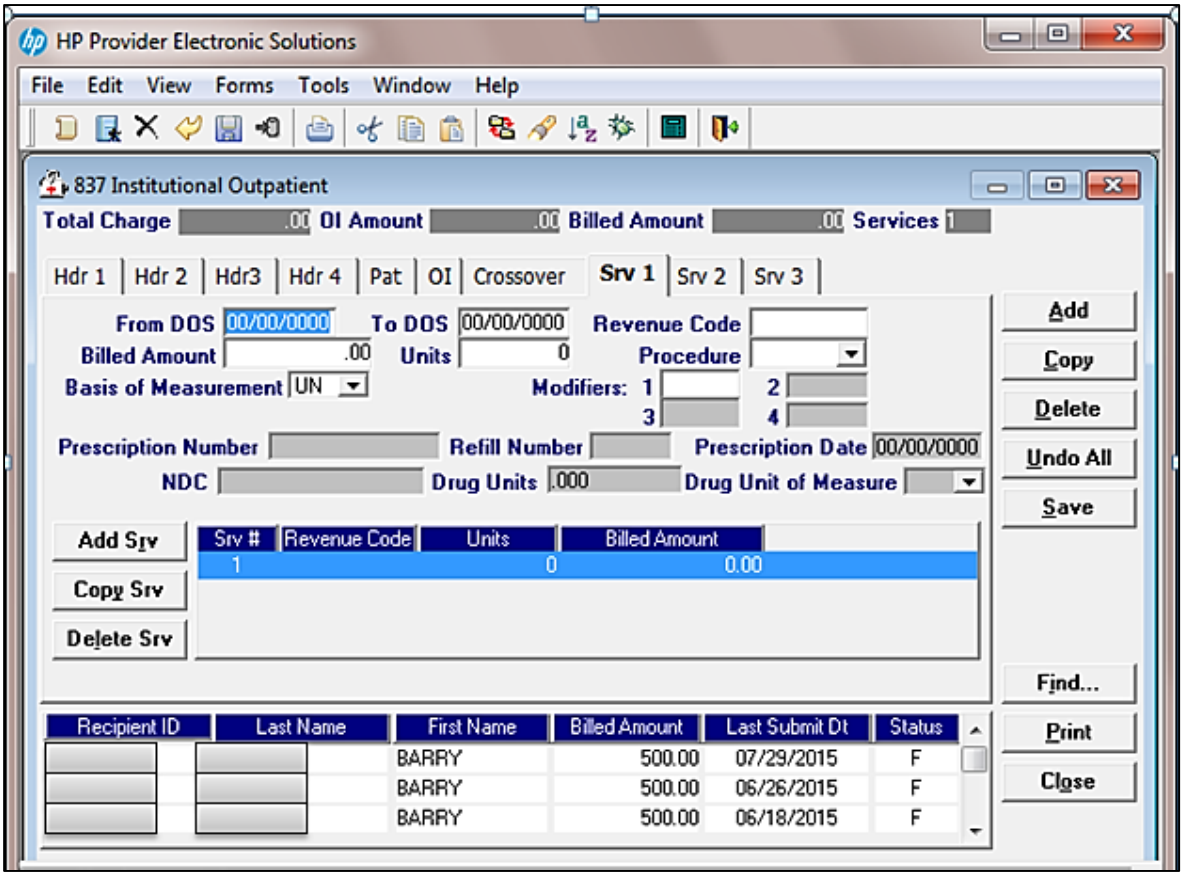
1 – Deductible Amount
118-ESRD Network Support Adjustment119 – Benefit Maximum for this time period has been reached
2 – Coinsurance Amount
23 – Payment adjusted because charges were paid by another payer
3 – Copayment Amount
35 – Lifetime Benefits Maximum has been reached
45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
50 – Non-covered services

In the right segment of this field, enter the amount of the adjustment. Use a decimal point.</td></tr>
<tr><td rowspan="2">Claim Filing Indicator Code</td><td colspan="2">Type of other insurance claim that is submitted. Select the appropriate claim code from the drop down list, or enter an appropriate value as specified:</td></tr>
<tr><td>MC – Medicaid
11 – Other Non-Federal Program
12 – Preferred Provider Organization (PPO)
13 – Point of Sale (POS)
14 – Exclusive Provider Organization (EPO)
15 – Indemnity Insurance
16 – Health Maintenance Organization (HMO) Medicare Risk
17 – Dental Maintenance Organization
AM – Automotive Medical
BL – Blue Cross/Blue Shield</td><td>CH – CHAMPUS
CI – Commercial Insurance Co
DS – Disability
FI – Federal Employees Program
HM – Health Maintenance Organization
LM – Liability Medical
MA – Medicare Part A
MB – Medicare Part B
OF – Other Federal Program
TV – Title V
VA – Veteran Administration Plan</td></tr>
</table>

		WC – Workers Compensation Health Claim **ZZ** – Mutually Defined
Adjustment Group Code	General category of the adjustment made to the claim. Select the adjustment group code from the drop down list, or enter an appropriate value as specified: **CO** – Contractual Obligations **CR** – Correction and Reversals **OA** – Other Adjustments **PI** – Payer Initiated Reductions **PR** –Patient Responsibility	
Payer Responsibility	Level of payer responsibility for the resident's other insurance. Select the appropriate code from the drop down list, or enter an appropriate value as specified: **P** – Payer 1 **S** – Payer 2 **T** – Payer 3 **A** – Payer 4 **B** – Payer 5 **C** – Payer 6 **D** – Payer 7 **E** – Payer 8 **F** – Payer 9 **G** – Payer 10 **H** – Payer 11 **U** – Unknown	
Full Medicare Days	Enter the number of days that are covered completely by Medicare.	
Medicare ICN	Enter the Medicare ICN found on the Medicare EOMB for the service billed.	
Paid Amount	Enter the Medicare coinsurance amount, using a decimal point. This information can be found on the Medicare EOMB. For example, enter 5.00 if the paid amount was $5.00. An amount of 0 (zero) may be entered.	

Paid Date	Enter the 2-digit month, 2-digit day, and 4-digit year the Medicare coinsurance was paid. This information can be found on the Medicare EOMB.
Carrier Code (Policy Holder)	Select the carrier code from the drop down list, or enter an appropriate value as specified. The carrier code identifies the recipient's third party insurance carrier.
Last Name (Policy Holder)	Policyholder's last name. This field is automatically populated after you select a carrier code from the Carrier Code field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
First Name (Policy Holder)	Policyholder's first name. This field is automatically populated after you select a carrier code from the Carrier Code field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*
Insurance Type Code (Policy Holder)	The window is only active if the payer is Medicare with Claim filing code of MB and the Payer Responsibility is not P (Primary). Select the appropriate value from the dropdown box, or enter an appropriate value as specified that identifies the type of insurance listed. (Insurance Type Code is a 'Do Not Use' field in the 837 Institutional Implementation Guide) **12** – Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan **13** –Medicare Secondary, End-Stage Renal Disease in the Mandated Coordination Period with an Employer's Group Health Plan **14** – Medicare Secondary, No-fault Insurance including Auto is Primary **15** – Medicare Secondary, Worker's Compensation **16** – Medicare Secondary Public Health Service (PHS) or Other Federal Agency **41** – Medicare Secondary Black Lung **42** – Medicare Secondary Veteran's Administration **43** – Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) **47** – Medicare Secondary, Other Liability Insurance is Primary

Step 9. Complete Service 1.


HP Provider Electronic Solutions
File Edit View Forms Tools Window Help
837 Institutional Outpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr3 Hdr 4 Pat OI Crossover Srv 1 Srv 2 Srv 3
From DOS 00/00/0000 To DOS 00/00/0000 Revenue Code
Billed Amount .00 Units 0 Procedure
Basis of Measurement UN Modifiers: 1 2 3 4
Prescription Number Refill Number Prescription Date 00/00/0000
NDC Drug Units .000 Drug Unit of Measure
Add Srv Copy Srv Delete Srv
Srv # Revenue Code Units Billed Amount
1 0 0.00
Add Copy Delete Undo All Save Find... Print Close
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
BARRY 500.00 07/29/2015 F
BARRY 500.00 06/26/2015 F
BARRY 500.00 06/18/2015 F

From DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient first received service under this claim. If you bill for a service that was provided on only one day, complete the From DOS with the date of service and press tab. The same date is automatically populated in the To DOS field.
To DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient last received service under this claim
Revenue Code	Enter the code that identifies a specific accommodation or ancillary service. This field accepts a maximum of four numeric characters. **0100** – Facility Days **0183** – Leave Days **0185** – Hospital Days
Billed Amount	Enter the usual charge to the self-paying public for the service provided, using a decimal point. If billing for multiple units, multiply the usual charge by the number of units billed and enter that amount. A zero billed amount is an appropriate value.

Units	Enter the number of units provided to the recipient for the service billed. Zero units is an appropriate value.
Procedure	Enter the appropriate procedure code as listed in the MA Program Fee Schedule, or select the procedure code from the drop down list, or enter an appropriate value as specified. The procedure code identifies the service that was rendered to the recipient.
Basis of Measurement	Select the basis code from the drop down list, or enter an appropriate value as specified. This field identifies the units in which a value is being expressed, or the manner in which a measurement was taken. **DA** – Days (Institutional) **UN** – Unit (Institutional and Professional)
Modifiers	Enter the 2-digit modifier for the procedure code entered in the Procedure field if the MA Program Fee Schedule indicates that the procedure code requires a modifier.
Prescription Number	Enter the prescription number that identifies the prescription. If the prescription number is less than 12 numeric characters, add zeroes to the beginning of the prescription number to make it equal to 12 characters. (ex. 000000001234) **Note:** Required if being used by Dispensing Provider.
Refill Number	Enter the refill number if a prescription is refilled. This field accepts one numeric character. **Note:** Required if being used by Dispensing Provider.
Prescription Date	Date Expressed in Format CCYYMMDD - Required when a drug is billed for this line and a prescription was written. **Note:** Required if being used by Dispensing Provider.
NDC	If dispensing medication, enter the NDC number in this field, using the 5-4-2 format. Zero-fill to complete the 5-4-2 format. Enter the zeroes in the beginning of the segment. (Ex: 00123-0123-01. *Dashes are not required in the field, but are shown for clarity*). **If you are dispensing medication, you will need to create a separate claim for the administration procedure.** **Note:** Required if being used by Dispensing Provider.
Drug Units	The actual count of Milliliters, Grams, or Units of a dispensed drug. **Note:** Required if being used by Dispensing Provider.

Drug Unit of Measure	Select the value from the drop down box, or enter an appropriate value as specified: **GR** – Gram **ML** Milliliter **UN** - Unit **Note:** Required if being used by Dispensing Provider.

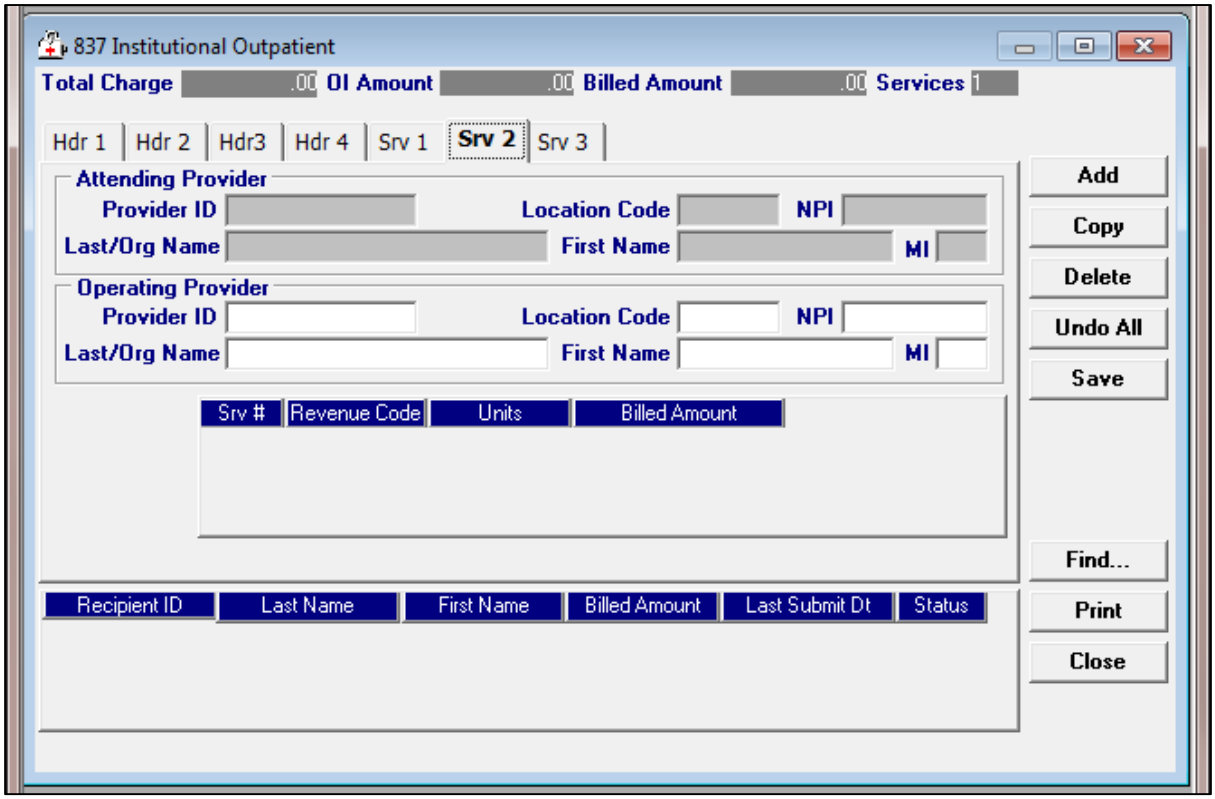
Step 9.1 To add additional service lines and revenue codes, click Add Srv. A new blank service line is added to the screen.

Step 9.2 Click on the new service line, and then enter the service data in the appropriate fields, as described above.

Step 9.3 To copy the data from an existing service line to a new service line, click on the existing service line you want to copy, then click Copy Srv. A new service line is added to the screen that has the same data as the previously selected service line. Edit the data in the new service line by clicking on the new service line, then making changes to the appropriate fields.

Step 9.4 To delete an existing service line, click on the service line that you want to delete, and then click Delete Srv. The selected service line is deleted.

Step 10. Complete Service 2.

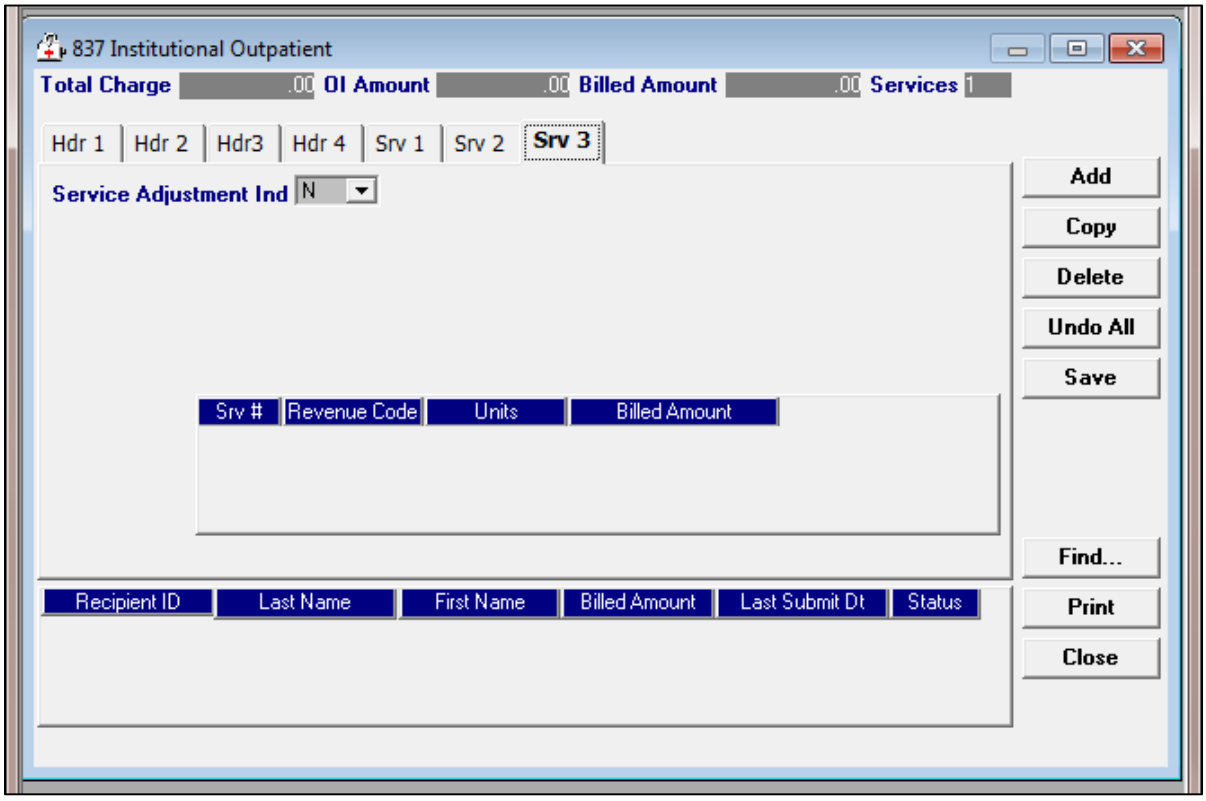


Provider ID (Attending Provider)	Select the 9-digit MPI number or 8- or 9-digit medical license number for the attending provider **ONLY IF** the attending provider on the service line is different from the attending provider for the claim itself.
Location Code (Attending Provider)	Attending provider's 4-digit location code. This field is automatically populated when an attending provider ID number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Attending Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Attending Provider)	Attending provider's last name or organization name associated with the number selected in the Attending Provider ID field. This field is automatically populated when an attending provider ID number is chosen.

	Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
First Name (Attending Provider)	Attending provider's first name. This field is automatically populated when an attending provider ID number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
MI (Attending Provider)	Attending provider's middle initial. This field is automatically populated when an attending provider ID number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Operating Provider (Operating Provider)	Select the 9-digit MPI number or 8- or 9-digit medical license number for the operating provider **ONLY IF** the operating provider on the service line is different from the operating provider for the claim itself.
Location Code (Operating Provider)	Operating provider's 4-digit location code associated with the number selected in the Operating Provider ID field. This field is automatically populated when an operating provider ID number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Operating Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Operating Provider)	Operating provider's last name or organization name associated with the number selected in the Operating Provider ID field. This field is automatically populated when an operating provider ID number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Operating Provider)	Operating provider's first name. This field is automatically populated when an operating provider ID number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
MI (Operating Provider)	Operating provider's middle initial. This field is automatically populated when an operating provider ID number is chosen.

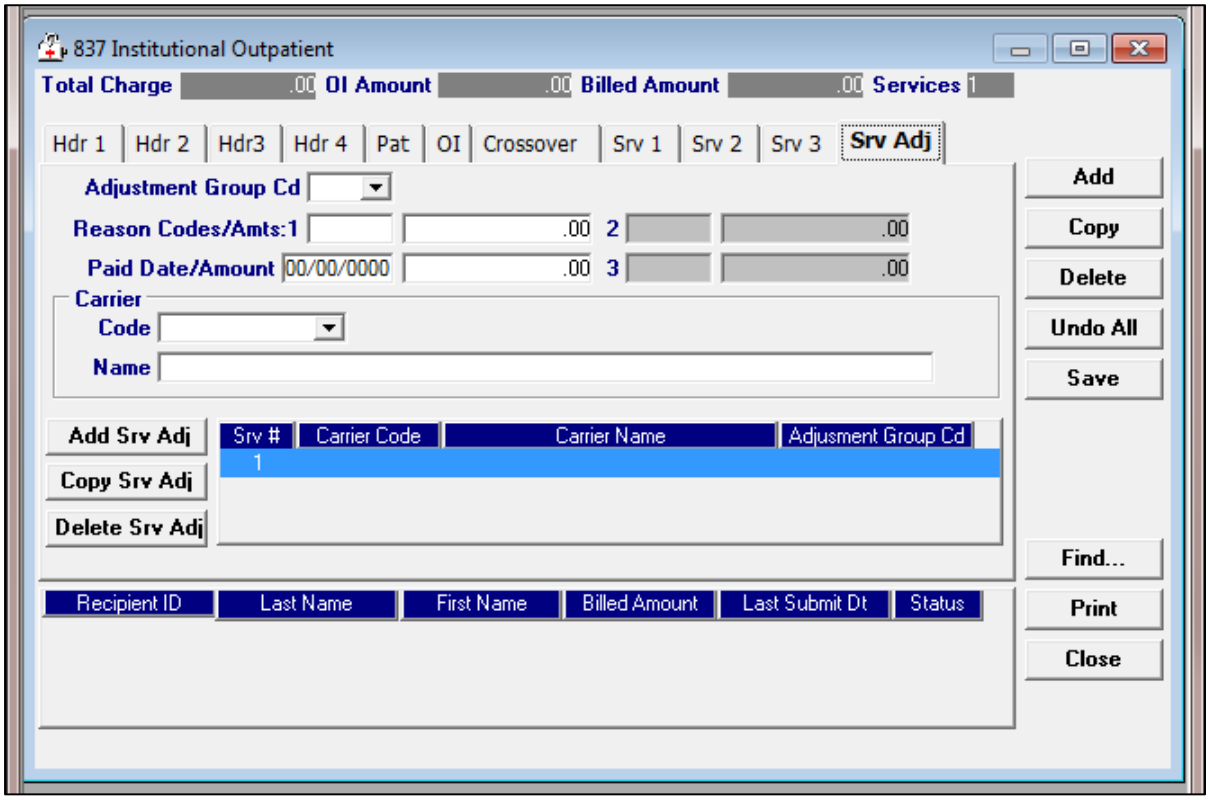
	Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.

Step 11. Complete Service 3.



Service Adjustment Indicator	Choose the appropriate option to indicate if there has been an adjustment against the claim by another payer. **Y** – Yes **N** - No

Step 12. Complete Service Adjustment.



Step 12.1 To access the Service Adjustment screen, set the Other Insurance Indicator on Header 3 to **Yes** and the Service Adjustment Indicator on Srv 3 to **Y**. The Service Adjustment screen is displayed.

Adjustment Group Code	General category of the adjustment made to the claim. Select the adjustment group code from the drop down list or enter an appropriate value as specified: **CO** – Contractual Obligation **CR** – Correction and Reversals **OA** – Other Adjustment **PI** – Payer Initiated Reductions **PR** – Patient Responsibility
Reason Codes/Amts	There are three Reason Code/Amount fields. Each field is divided into two segments. In the left segment of the field, select the appropriate reason code from the segment's drop down list, or enter an appropriate value as specified. The reason code identifies the reason the adjustment is being made to the claim line. **1** – Deductible Amount **118**-ESRD Network Support Adjustment

	119 – Benefit Maximum for this time period has been reached **2** – Coinsurance Amount **23** – Payment adjusted because charges were paid by another payer **3** – Copayment Amount **35** – Lifetime Benefits Maximum has been reached **45** - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement **50** – Non-covered services In the right segment of this field, enter the amount of the adjustment, using a decimal point.
Paid Date / Amount	In the left segment of this field, enter the date on which the other insurance carrier paid an amount toward the claim. Use a 2-digit month, 2-digit day, and 4-digit year format. In the right segment of this field, enter the amount the other insurance carrier paid toward the claim. Use a decimal point.
Carrier Code	Select the carrier code for the insurance company that paid toward the claim from the drop down list, or enter an appropriate value as specified**.**
Name	Name of the person or entity who accepts the insurance policy indicated in the Carrier Code field. This field is automatically populated when a Carrier code is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Policy Holder Form.*

Step 12.2 The service adjustment lines are linked to the claim line that is highlighted when you access the Service Adjustment screen. Make sure that you have the correct service line highlighted.

Step 13. Click

to save the Institutional Outpatient form.

Step 14. Click

to start another Institutional Outpatient form.

9.8 Complete a 837 Professional Form

The 837 Professional Form is used to create claims for outpatient services.

Note: Dispensing Providers should use this option for submitting and voiding claims

Note: Consolidated Community Reporting for OMHSAS (CCR) submissions can now be performed using PES software Version 3.57.

The 837 Professional Form is divided into eleven screens. Each screen contains the following data:

Hdr 1	Accesses the screen that contains the provider and recipient information.
Hdr 2	Accesses the screen that contains the diagnosis information, emergency indicator patient paid, place of service, prior authorization and contract information. **Note:** Consolidated Community Reporting for OMHSAS (CCR) encounter submissions are indicated using the Encounter Ind. To submit an encounter, select "RP" from the field's drop down list.
Hdr 3	Accesses the screen that contains accident, ambulance, and admission information.
Hdr 4	Accesses the screen that contains any referring, rendering provider, service facility and supervising provider information.
Hdr 5	Accesses the screen that contains condition codes and ambulance information.
Pat	Accesses the screen that contains patient information for newborn recipients.
Other Insurance	Accesses the screen that contains other insurance carrier information and can be accessed by selecting **Y**, in the Other Insurance Ind field, located under the Header 3 tab. **Note:** The MCO ICN is required for Consolidated Community Reporting for OMHSAS (CCR) encounters submissions.
Srv 1	Accesses the screen that contains service information.
Srv 2	Accesses the screen that contains ambulance information for individual service lines.
Srv 3	Accesses the screen that contains additional rendering provider information and the service adjustment indicator.
Srv Adj	Accesses the screen that contains third party insurance carrier adjustment information. It can be accessed by selecting **Y** in the Other Insurance Ind field located under the Header 3 tab, and then selecting **Y** in the Service Adjustment Ind field located under the Service 3 Screen.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

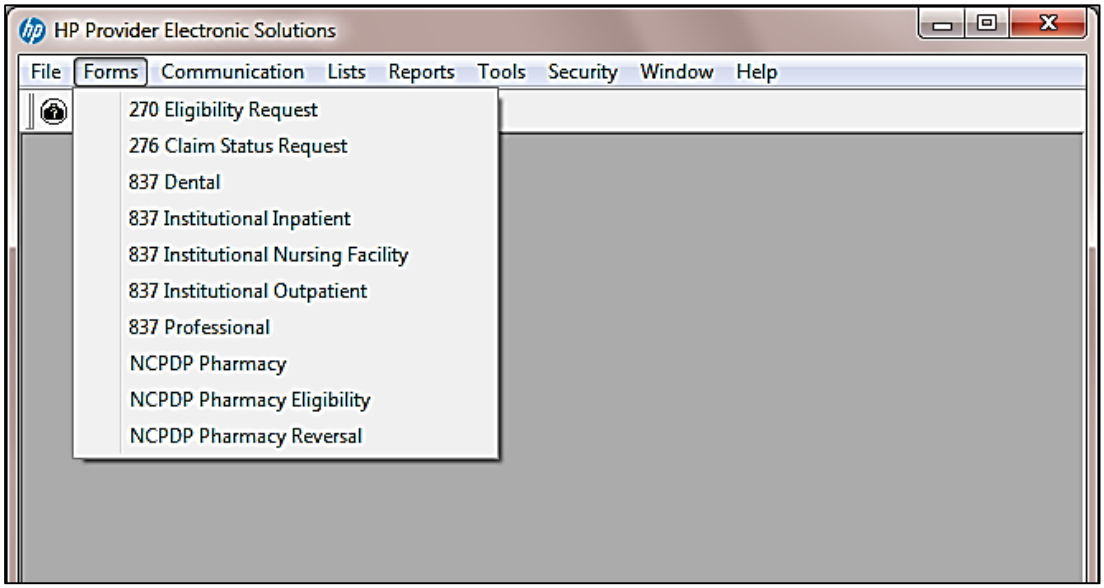
To create a Professional claim, perform the following steps:

Step 1. From the Provider Electronic Solutions software main window access the 837 Professional Form on one of the other:

Click (837 Professional Shortcut Button) on the Toolbar

or

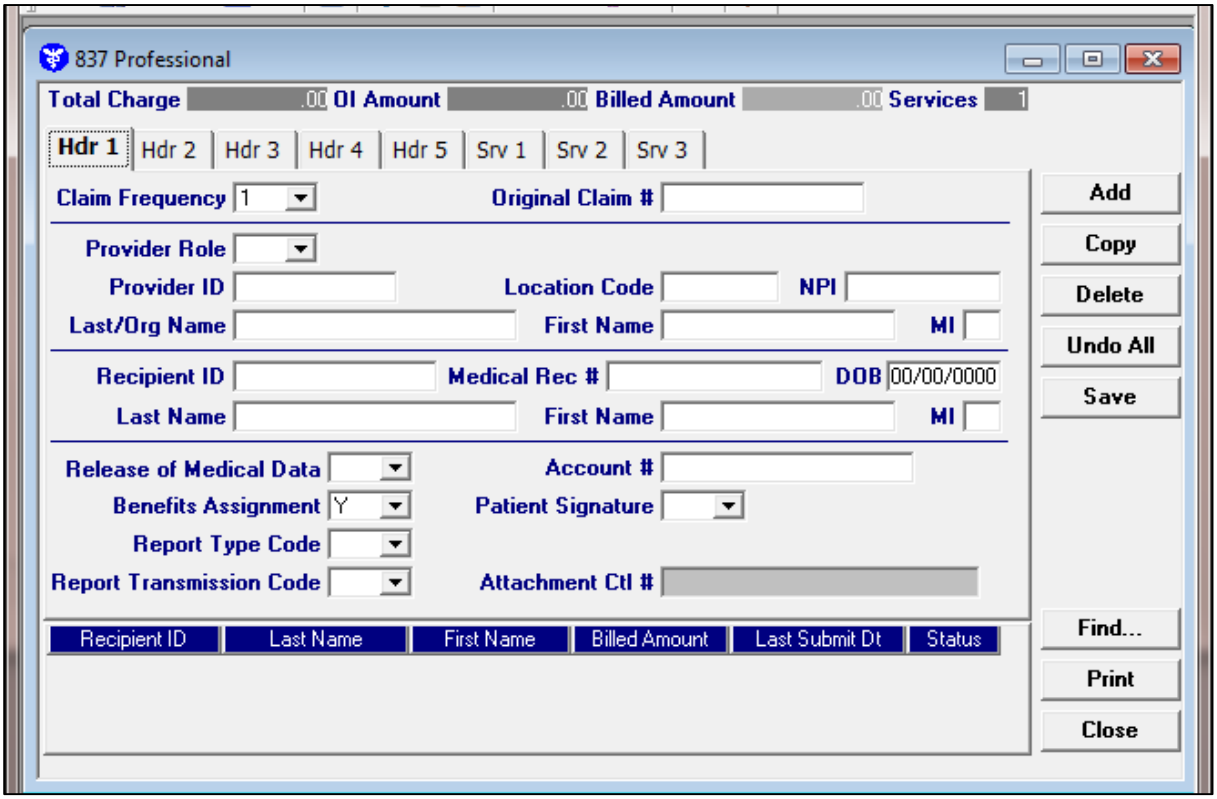
Select the 837 Professional option from the Forms drop down menu.



Note: When you choose a selection from a drop down list, many fields are populated. A drop down list is also known as a reference list. For additional information on reference lists, refer to the List options under Section 6.

Step 2. The 837 Professional Form appears, with the Header 1 screen displayed.

Step 3. Complete Header 1.



Claim Frequency	Frequency in which the claim is/was submitted. Select the appropriate frequency code from the drop down list or enter an appropriate value as specified:
0 – No Pay Claim	Use this code when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill (for example, the patient pay is equal to or exceeds the amount billed).
1 – Original/ (Admit thru Discharge claim) Rebill	Used when billing MA for new or previously unpaid service(s). This code is also used to resubmit a specific bill that has been previously rejected.
7 – Replacement (Replacement of Prior Claim	Used to adjust a previously paid claim, as necessary.
8 – Void (Void/Cancel of Prior Claim**)**	Reflects the cancellation or voiding of a previously paid bill.

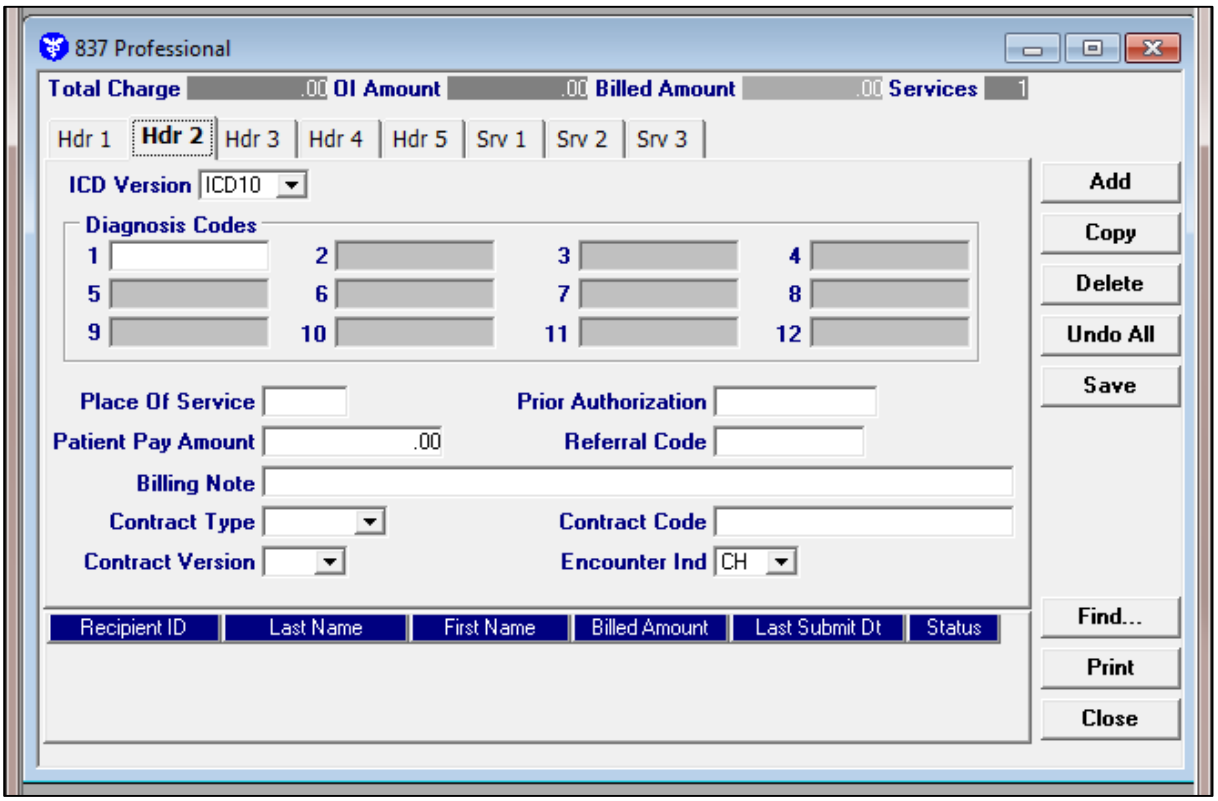
	Note: Dispensing Providers must use the Claim Frequency 8 to Void claims – Claim Frequency Code 7 (Adjustments) is not supported
Original Claim #	If resubmitting a previously rejected claim, or a claim for adjustment, enter the 13-digit ICN as printed on the RA statement. If resubmitting a claim or an adjustment that was processed prior to the implementation of PROMISe™, enter the 10-digit CRN followed by the 2-digit line number as it is printed on the RA statement.
Provider Role	Select the provider role code from the drop down list, or enter the appropriate value, as described below: Select **1,** Group - if the MA number entered is for a group practice. Select **2,** Non-Group - if the MA number entered is for an individual provider. If for a group practice, individual rendering provider information is required.
Provider ID	Select the 9-digit MPI number from the drop down list for the provider under whom the claim will be paid, or double-click on the data entry portion of the field to add a reference list selection.
Location Code	Provider's 4-digit service location code associated with the MPI number selected in the Provider ID field. This field is automatically populated when an MPI number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name	Provider's last name or the name of the group. This field is automatically populated when an MPI number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name	Provider's first name. This field is automatically populated when an MPI number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*

MI	Provider's middle initial. This field is automatically populated when an MPI number is chosen. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Recipient ID	The recipient's 10-digit recipient number. For additional information on the Recipient ID field, refer to *Recipient Reference List* in section 8.3 of this manual. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Medical Record #	Medical record number assigned by your office to the recipient. This field is automatically populated after you select a Recipient number from the Recipient ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
DOB	Recipient's date of birth. This field is automatically populated after you select a Recipient number from the Recipient ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
Last Name	Recipient's last name. This field is automatically populated after you select a recipient number from the Recipient ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
First Name	Recipient's first name. This field is automatically populated after you select a recipient number from the Recipient ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
MI	Recipient's middle initial. This field is automatically populated after you select a recipient number from the Recipient ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Recipient Form.*
Release of Medical Data	Select the appropriate release code from the drop down list or enter an appropriate value as specified: Select **I** – Informed Consent to Release Medical Information-Informed consent to release medical information for billing.

	Select **Y** – Yes, Provider has a signed Statement Permitting Release of Medical Billing Data Related to a Claim-Provider has a signed statement on file that permits the release of medical data to other organizations.	
Account #	Enter the account number assigned to the recipient by the provider for the service that was performed. This information is returned on the RA statement. A unique account number is required for each claim submitted to be able to obtain claim status information. If the same account number is used for each claim submitted when a claim status request is sent, the claim status is reported on **all** claims with that account number.	
Benefits Assignment	Select the appropriate assignment code from the drop down list or enter an appropriate value, as specified: Select **Y**– if the recipient or authorized person has authorized that benefits be assigned to the provider. Select **N** – if the recipient or authorized person has not authorized that benefits be assigned to the provider. Select **W** – for Not Applicable – Not applicable for this claim	
Patient Signature	The signature code identifies how the recipient or authorized person's signature was obtained, and how the provider retains it. Select the appropriate signature code from the drop down list, or enter an appropriate value, as specified: **P** – Signature generated by provider because the patient was not physically present for service.	
Report Type Code	Enter the appropriate code for the type of attachment submitted as specified, or select the appropriate code from this drop down list:	
	AS – Admission Summary **B2** – Prescription **B3** – Physician Order **B4** – Referral Form **CT** – Certification **DA** – Dental Models **DG** – Diagnostic Report **DS** – Discharge Summary **EB** – Explanation of Benefits **MT** - Models	**NN** - Nursing Notes **OB** – Operative Notes **OZ** – Support Data for Claim **PN** – Physical Therapy Notes **PO** – Prosthetics and Orthotic Certification **PZ** – Physical Therapy Certification **RB** – Radiology Films **RR** – Radiology Reports **RT** – Report of Tests and Analysis Report

Report Transmission Code	Enter the appropriate code for the method of attachment transmission: **AA** – Available on request at provider site **BM** – By mail **EL** – Electronically Only **EM** – E-Mail **FT** - File Transfer **FX** – By Fax
Attachment Control Number	Enter the 9-digit attachment control number obtained from the PROMISe™ web site. This number is used when a paper attachment is required by MA to cross reference the paper attachment with the electronic claim. This number must also be written on the cover letter sent to MA.

Step 4. Complete Header 2.



ICD Version	Use the ICD 9/ICD10 Version for the code being submitted.
Diagnosis Codes, Fields 1-12	Each field can contain a specific ICD-9-CM/ICD-10-CM/PCS diagnosis code that relates to the recipient's visit. The primary ICD-9-CM/ICD-10-CM/PCS code must be entered in the first field.

<table>
<tr><td>Place of Service</td><td colspan="2">Select the appropriate place of service code from the drop down list, or enter an appropriate value as specified. This field identifies the location where the service was performed.</td></tr>
<tr><td></td><td>03 – School
04 – Homeless Shelter
11 – Office
12- Patient’s Home
15 – Mobile Unit
21 – Inpatient Hospital
22 – Outpatient Hospital
23 – Emergency Room-Hospital
24 – Ambulatory Surgical Center-ASC/SPU
25 – Birthing Center
26 – Military Treatment Center
31 – Skilled Nursing Facility
32 - Nursing Facility
33 – Custodial Care Facility
34 – Hospice
35 - Adult Living Care Facility
41 – Ambulance – Land
42 – Ambulance – Air or Water
50 – Federally Qualified Health Center
51 – Inpatient Psychiatric Facility
52 – Psychiatric Facility Partial Hospitalization</td><td>53 – Community Mental Health Care
54 – Intermediate Care Facility/Mentally Retarded
55 – Residential Substance Abuse Treatment Facility
56 – Psychiatric Residential Treatment Center (Non-JCHAO)
60 – Mass Immunization Center
61 – Comprehensive Inpatient Rehabilitation Facility
62 – CORF - Comprehensive Outpatient Rehabilitation Facility
65 – End Stage Renal Disease Treatment Facility
71 – State or Local Public Health Clinic
72 – Rural Health Clinic
81 – Independent Laboratory
99 – Other Unlisted Facility</td></tr>
<tr><td>Prior Authorization</td><td colspan="2">Enter the 10-digit CHR/DRG/PSR admission certification number.
Enter the 10-digit Prior Authorization number if the service requires and has received prior authorization.
Enter the 10-digit PSR Number if admission to an acute care hospital, a hospital SPU, or an ASC is elective.
Enter the 10-digit Admission Certification number for urgent or emergency admission to an acute care hospital, a SPU, an ASC, or specialty hospital.
Enter the 10-digit GA Voucher Exception for approved GA voucher exception requests.</td></tr>
</table>

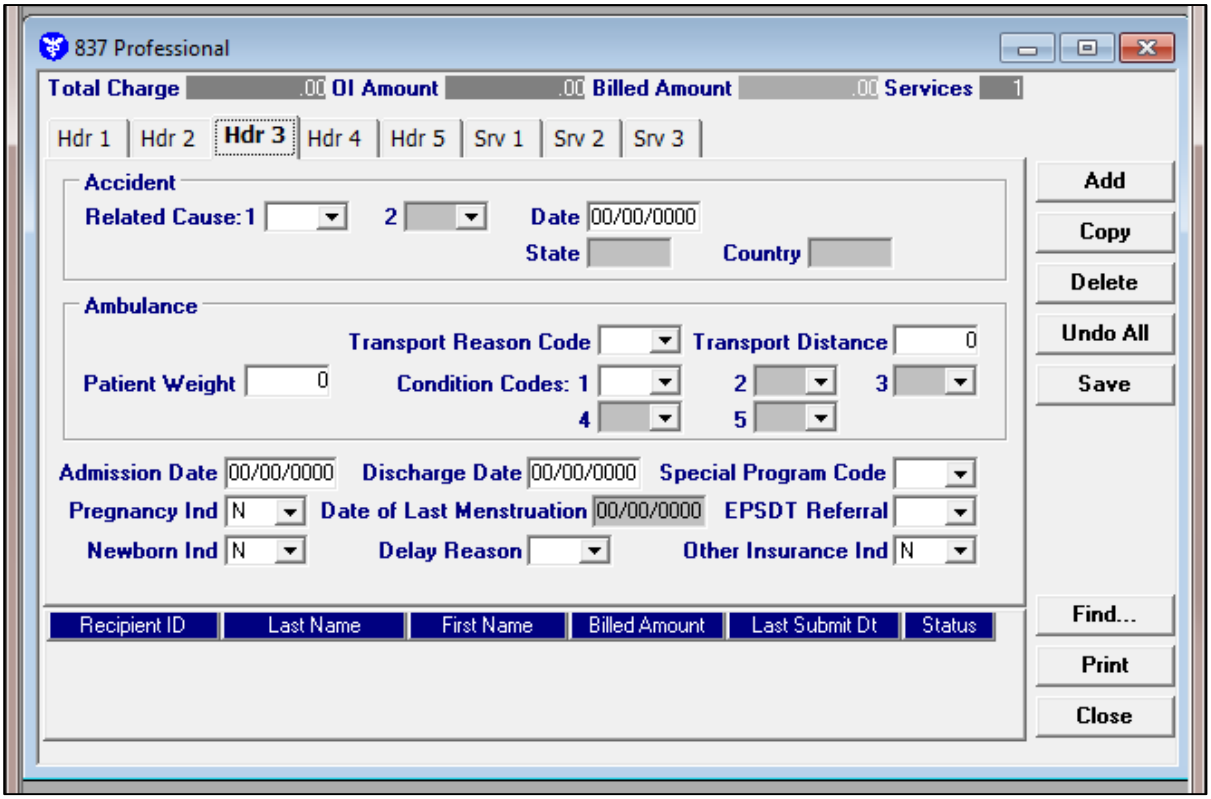
<table>
<tr><td></td><td>Enter the 10-digit authorization number for approved 1150 Administrative Waiver services.</td></tr>
<tr><td>Patient Pay Amount</td><td>Enter the amount, using a decimal point, the recipient has paid toward this claim, as determined by the local CAO. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM. For example, enter 25.50 if the amount was $25.50. Do not enter copay in this field</td></tr>
<tr><td>Referral Code</td><td>Enter a 2-digit alphanumeric code that identifies the Primary Care Case Manager, if applicable. Not currently used.</td></tr>
<tr><td>Billing Note</td><td>This field pertains to information related to visit codes and additional information required to adjudicate MA claims. Enter the following codes if they apply: (Multiple codes should be entered in one string, ex: VC09QSB)

If the provider is a qualified small business, enter QSB in the Billing Note field. You may enter more than one code, if applicable. Example: VC09QSB for a claim filed by a qualified small business dental provider for services rendered to a pregnant woman.
<table>
<tr><th>If the visit code is…</th><th>This means…</th><th>Then Enter…</th></tr>
<tr><td>09</td><td>Services rendered to a pregnant woman (Dental only)</td><td>VC09</td></tr>
<tr><td>10</td><td>Services rendered to an LTC or a state mental hospital resident</td><td>VC10</td></tr>
<tr><td>11</td><td>Provider attempted but was unsuccessful in collecting a co-payment</td><td>VC11</td></tr>
<tr><td>QSB</td><td>If the provider is a Qualified Small Business</td><td>QSB</td></tr>
<tr><td>EPSDT</td><td>If the claim involved EPSDT referral information, any of the following that apply must be entered:</td><td></td></tr>
<tr><td></td><td>EPSDT – Dental Referral</td><td>YD</td></tr>
</table>
</td></tr>
</table>

		EPSDT – Vision Referral	**YV**
		EPSDT – Hearing Referral	**YH**
		EPSDT – Medical Referral	**YM**
		EPSDT – Behavioral Health Referral	**YB**
		EPSDT – Other Referral	**YO**

Contract Type	The indicator represents the contract between the provider and the managed care or sub-capitation subcontractor. Choose a value from the drop-down list. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Code	The contract number between the provider and the managed care or sub-capitation subcontractor. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Version	Enter the contract number held with DHS. This field is used only by Consolidated Community Reporting for OMHSAS (CCR) submitter. The contract version is the month of the contract that was in force at the time of the service. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR) Values **01** thru **12**
Encounter Indicator	Use the Encounter Indicator drop down menu to enter the appropriate value. To submit an encounter, select "RP" for the menu. o Select RP, if the claim is an encounter record (Consolidated Community Reporting Use Only) o Select CH, if the claim is a Fee for Service claim. The default value for this field is CH. **Note:** Consolidated Community Reporting for OMHSAS (CCR) submissions are indicated using the Encounter Ind. value of RP. The default value for this field is CH.

Step 5. Complete Header 3.

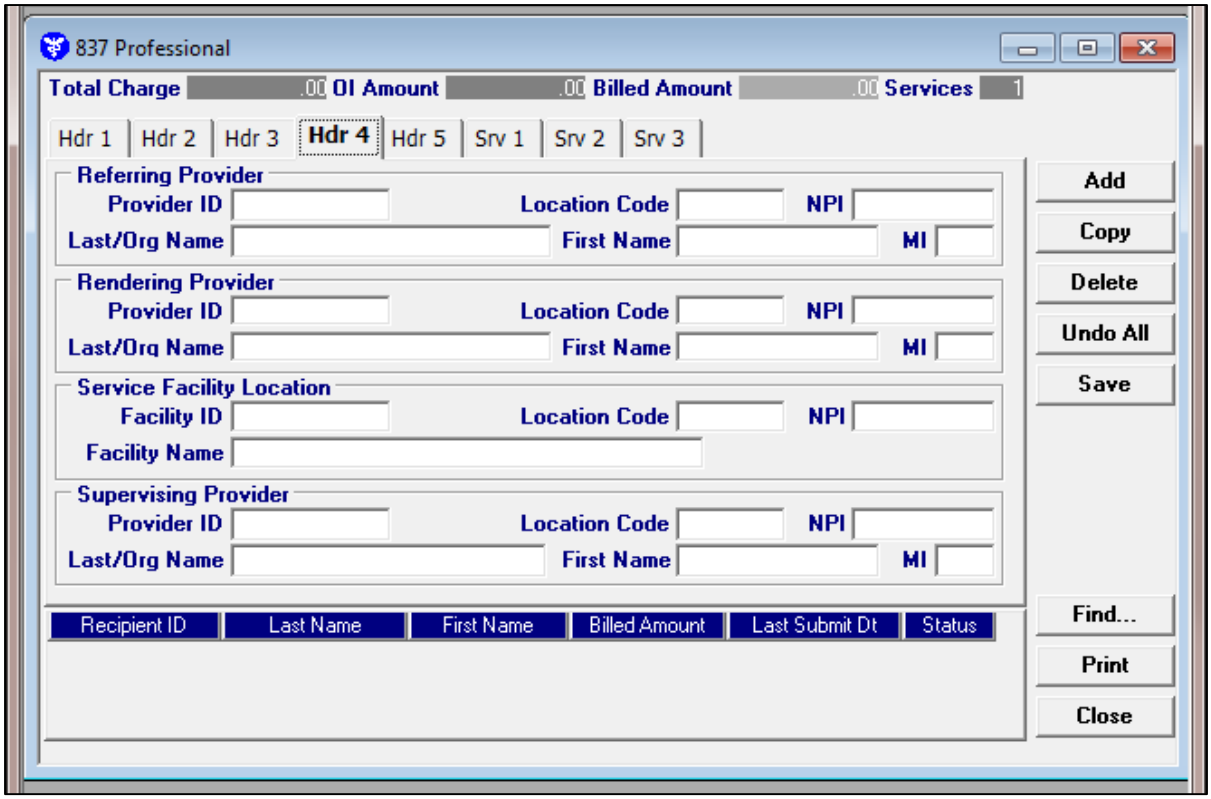

837 Professional
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 Srv 1 Srv 2 Srv 3
Accident
Related Cause: 1 2 Date 00/00/0000
State Country
Ambulance
Transport Reason Code Transport Distance 0
Patient Weight 0 Condition Codes: 1 2 3
4 5
Admission Date 00/00/0000 Discharge Date 00/00/0000 Special Program Code
Pregnancy Ind N Date of Last Menstruation 00/00/0000 EPSDT Referral
Newborn Ind N Delay Reason Other Insurance Ind N
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

Related Cause: (Accident)	1-2 Select the value from the drop down list or enter an appropriate value as specified. **AA** – Auto-Accident **EM** – Employment **OA -** Other Accident
Date (Accident)	Enter the 2-digit month, 2-digit day, and 4-digit year on which the accident that related to charges or to the recipient's current condition, diagnosis, or referenced treatment occurred. For example, enter 10012015 if the date of the accident was October 1, 2015.
State (Accident)	Enter the two-letter abbreviation for the state where the accident occurred. For example, enter **PA** for Pennsylvania.
Country (Accident)	If the auto accident occurred outside of the United States, enter three-letter country abbreviation where the auto accident occurred. For example, enter **CAN** for Canada.
Transport Reason Code (Ambulance)	Reason ambulance transport was used. Please follow current ambulance policy when choosing a transport reason code. Select the

	reason code from the drop down list, or enter an appropriate value, as specified: **A** – Patient was transported to nearest facility for care of symptoms, complaints, or both. **B** – Patient was transported for the benefit of a preferred physician. **C** – Patient was transported for the nearness of family members. **D** – Patient was transported for the care of a specialist or for availability of specialized equipment. **E** – Patient Transferred to Rehabilitation Facility
Transport Distance (Ambulance)	Enter the number of miles the recipient was transported by ambulance. This field accepts (up to) four numeric characters.
Patient Weight (Ambulance)	Enter the weight of the recipient in pounds at the time of transport by ambulance. This field accepts (up to) four numeric characters.
Condition Codes (Ambulance)	Each field identifies a condition relating to the bill that may affect payer processing. Select the appropriate code from the drop down list or enter an appropriate value, as specified: **01 –** Patient was admitted to a hospital. **04 –** Patient was moved by stretcher. **05 –** Patient was unconscious or in shock. **06 –** Patient was transported in an emergency situation. **07 –** Patient had to be physically restrained. **08 –** Patient had visible hemorrhaging. **09 –** Ambulance service was medically necessary. **12 –** Patient is confined to a bed or chair
Admission Date	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient was admitted to a facility. For example, enter 10012015 if the date was October 1, 2015.
Discharge Date	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient was discharged from a facility. For example, enter 1001215 if the date was October 1, 2015. If the recipient has not yet been discharged when the claim is filed, enter eight zeros in this field.
Special Program Code	The special program code indicates the claim was submitted under one of the circumstances, programs, or projects listed. Enter the appropriate value from the drop down box, or enter an appropriate value as specified.

	02 – Physically Handicapped Children's Program **03** – Special Federal Funding **05** – Disability	
Pregnancy Indicator	Select the pregnancy code from the drop down list, or enter the appropriate value. Select **Y —** Yes-if the recipient was pregnant at the time of service. Select **N —** No-if the recipient was not pregnant at the time of service.	
Date of Last Menstruation	Enter the 2-digit month, 2-digit day, and 4-digit year of the mother's last menstruation. If the date is unknown, enter the first date that you saw the recipient.	
EPSDT Referral	Enter the appropriate value from the drop down list or enter an appropriate value as specified. **AV** – Availability not used **NU** – Not used **S2** – Under treatment **ST** – New service	
Newborn Indicator	Select **Y –** Yes-from the drop down list if services were rendered to a newborn. Select **N** – No-from the drop down list.	
Delay Reason	Select the appropriate code to indicate why a claim is being submitted outside of the 180-day initial submission window. This field is optional:	
	1 – Proof of Eligibility Unknown or Unavailable **2** – Litigation **3** – Authorization Delays **4** – Delay in Certifying Provider **5** – Delay in Supplying Billing Forms **6** – Delay in Delivery of Custom-Made Appliances	**7** – Third Party Processing Delay **8** – Delay in Eligibility Determination **9** – Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules **10** – Administration Delay in the Prior Authorization Process **11** - Other
Other Insurance Indicator	Select the other insurance code from the drop down list, or enter an appropriate value as specified. Select **Y —** Yes-if the recipient has other insurance. If you select Y, the other insurance screen will be added to the claim. Select **N —** No-if the recipient does not have other insurance.	

Step 6. Complete Header 4.



Provider ID (Referring Provider)	Enter the 8- or 9- digit medical license number or MPI number for the physician who referred the recipient for the service performed, or double-click in the data entry portion of the field to add a reference list selection. **Note:** The Referring Provider is required for all provider types. **Note:** Dispensing Providers – Referring Provider is the Prescriber and must be submitted with an NPI. **Note**: For Access Plus Referred Services, select the 13-digit MAID number for the referring provider from the field's pull down list.
Location Code (Referring Provider)	Referring provider's 4-digit service facility location number for the MPI number selected in the Referring Provider ID field. This field is automatically populated with the correct information after an MPI number is selected in the Referring Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*

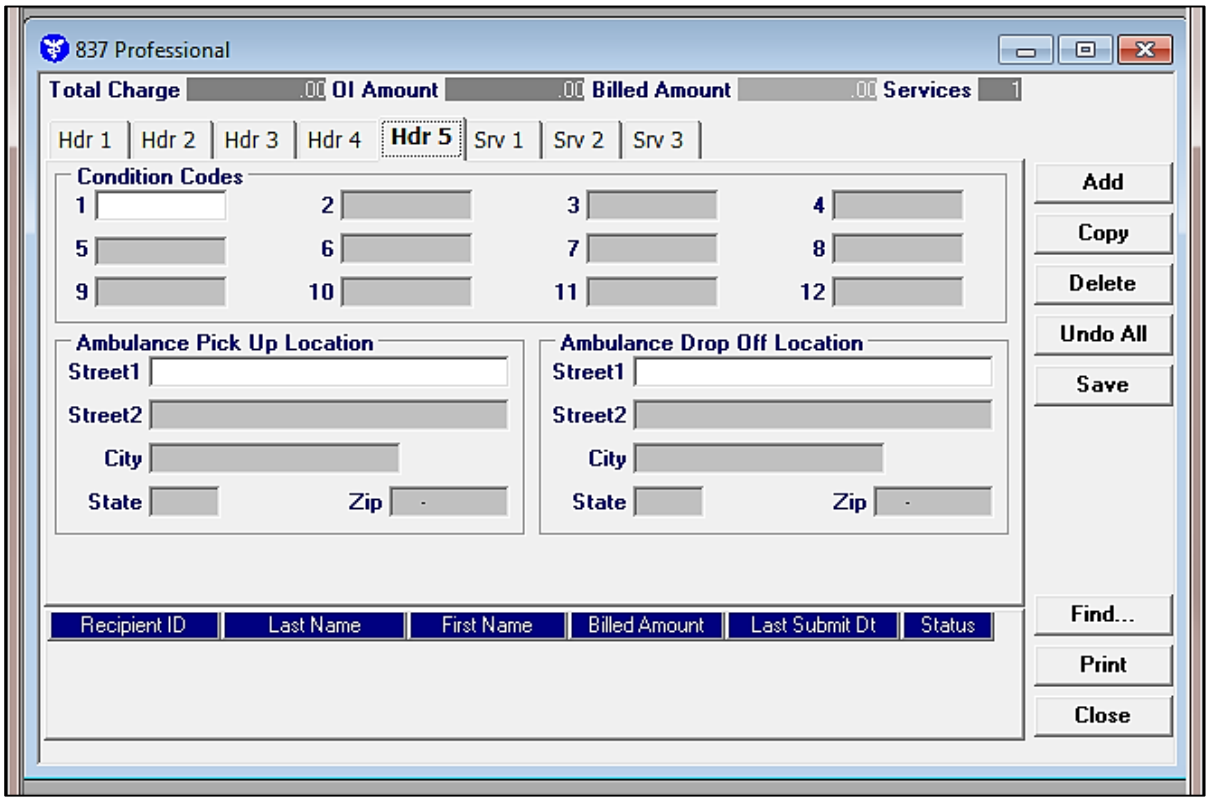
NPI (Referring Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Referring Provider)	Referring provider's last name or organization name. This field is automatically populated with the correct information after an MPI number is selected in the Referring Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
First Name (Referring Provider)	Referring provider's first name. This field is automatically populated with the correct information after an MPI number is selected in the Referring Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form*
Middle Initial (Referring Provider)	Referring provider's middle initial. This field is automatically populated with the correct information after an MPI number is selected in the Referring Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Provider ID (Rendering Provider)	Provider who rendered the service. Select the 9-digit MPI number for the provider of service(s) from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. Complete this field if a group's MA ID was entered on Header 1 (indicates that a group receives the payment, instead of an individual provider).
Location Code (Rendering Provider)	Rendering provider's 4-digit service facility location number for the MPI number selected in the Referring Provider ID field. This field is automatically populated with the correct information after an MPI number is selected in the Rendering Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Rendering Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name (Rendering Provider)	Rendering provider's last name or organization name. This field is automatically populated with the correct information after an MPI number is selected in the Rendering Provider ID field.

	Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.
First Name (Rendering Provider)	Rendering provider's first name. This field is automatically populated with the correct information after an MPI number is selected in the Rendering Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form*
MI (Rendering Provider)	Rendering provider's middle initial. This field is automatically populated with the correct information after an MPI number is selected in the Rendering Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Facility ID (Service Facility Location)	If the services are being rendered **only** in an inpatient hospital, emergency room, hospital special treatment room, hospital short procedure unit, ambulatory surgical center, or a renal dialysis center: Select the ID number for the service facility location from the drop down list, ***or*** Double-click on the data entry portion of the field to add a reference list selection. The format of the Facility ID should be the 9-digit MPI number provided by the facility.
Location Code (Service Facility Location)	The 4-digit service facility location code associated with the MPI number selected in the Service Facility ID number field. This field is automatically populated with the correct information after an MPI number is selected in the Facility ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Service Facility Location)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Facility Name (Service Facility Location)	Facility name, if the services are being rendered in an inpatient hospital emergency room, hospital special treatment room, hospital short procedure unit, ambulatory surgical center, or a renal dialysis center. This field is automatically populated with the correct

	information after an MPI number is selected in the Facility ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form*
Provider ID (Supervising Provider)	Select the 9-digit MPI number for the provider that the claim will be paid under (billing provider) from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.- **Required when the rendering provider is supervised by a physician or dentist.** Individual last name or organizational name
Location Code (Supervising Provider)	4-digit location code associated with the MPI number selected in the Provider ID field. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.* **Required when the rendering provider is supervised by a physician or dentist.**
NPI (Supervising Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position. Required when the rendering provider is supervised by a physician or dentist.
Last/Org Name (Supervising Provider)	Supervising Provider's last name or the name of the group or facility. This field is automatically populated after you select or enter an MPI number in the Provider ID field. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider.* **Required when the rendering provider is supervised by a physician or dentist.**
First Name (Supervising Provider)	Supervising provider's first name. This field is automatically populated after you select or enter an MPI number in the Provider ID field. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form. **Required when the rendering provider is supervised by a physician or dentist.**

MI (Supervising Provider)	Supervising provider's middle initial. This field is automatically populated after you select or enter an MPI number in the Provider ID field. Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form. **Required when the rendering provider is supervised by a physician or dentist.**

Step 7. Complete Header 5.

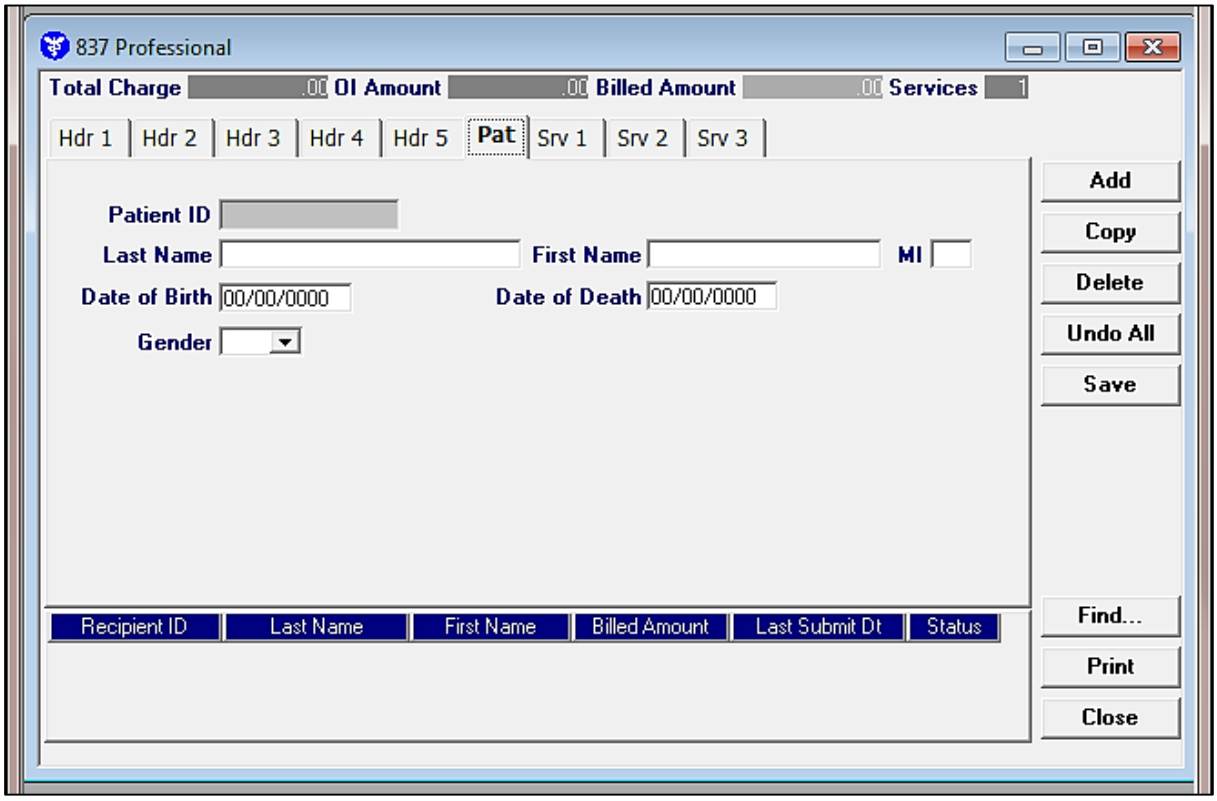


Condition Code (1-12)	Choose the appropriate code from the drop down list, or enter an appropriate value as specified that identifies conditions relating to a bill that may affect payer processing: **02** – Condition is Employment Related **03** – Patient Covered by Insurance Not Reflected Here **05** – Lien Has Been Filed **77** – Payment was accepted as payment in full **A1** – EPSDT/CHAP **A3** – Special Federal Funding **A4** – Family Planning

	A7 – Induced Abortion – Danger to Life **A8 –** Inducted Abortion – Victim Rape/incest **AI** – Sterilization **B3** – Pregnancy Indicator **DR** – Disaster Related
Street 1 (Ambulance Pick Up Location)	Enter the street address.
Street 2 (Ambulance Pick Up Location**)**	Enter additional address information, such as suite or apartment number
City (Ambulance Pick Up Location)	Enter the City that corresponds with the street address.
State (Ambulance Pick Up Location)	Enter the two-letter abbreviation for the state that corresponds with the city listed in the City field.
Zip (Ambulance Pick Up Location)	Enter the 9-digit zip code corresponding to the city and state listed in the City and State fields. This field holds a maximum of 9-numeric characters. **Note:** If entering an NPI as the primary identifier, you must use the correct Nine-Digit Zip Code that you coordinated with Provider Enrollment for your legacy ID (Nine Digit Provider ID plus Four-Digit Service Location Code).
Street 1 (Ambulance Drop Off Location)	Enter the street address.
Street 2 (Ambulance Drop Off Location)	Enter additional address information, such as suite or apartment number
City (Ambulance Drop Off Location)	Enter the City that corresponds with the street address.
State (Ambulance Drop Off Location)	Enter the two-letter abbreviation for the state that corresponds with the city listed in the City field.
Zip (Ambulance Drop Off Location)	Enter the 9-digit zip code corresponding to the city and state listed in the City and State fields. This field holds a maximum of 9-numeric characters. **Note:** If entering an NPI as the primary identifier, you must use the correct Nine-Digit Zip Code that you coordinated with Provider Enrollment for your legacy

	ID (Nine Digit Provider ID plus Four-Digit Service Location Code).

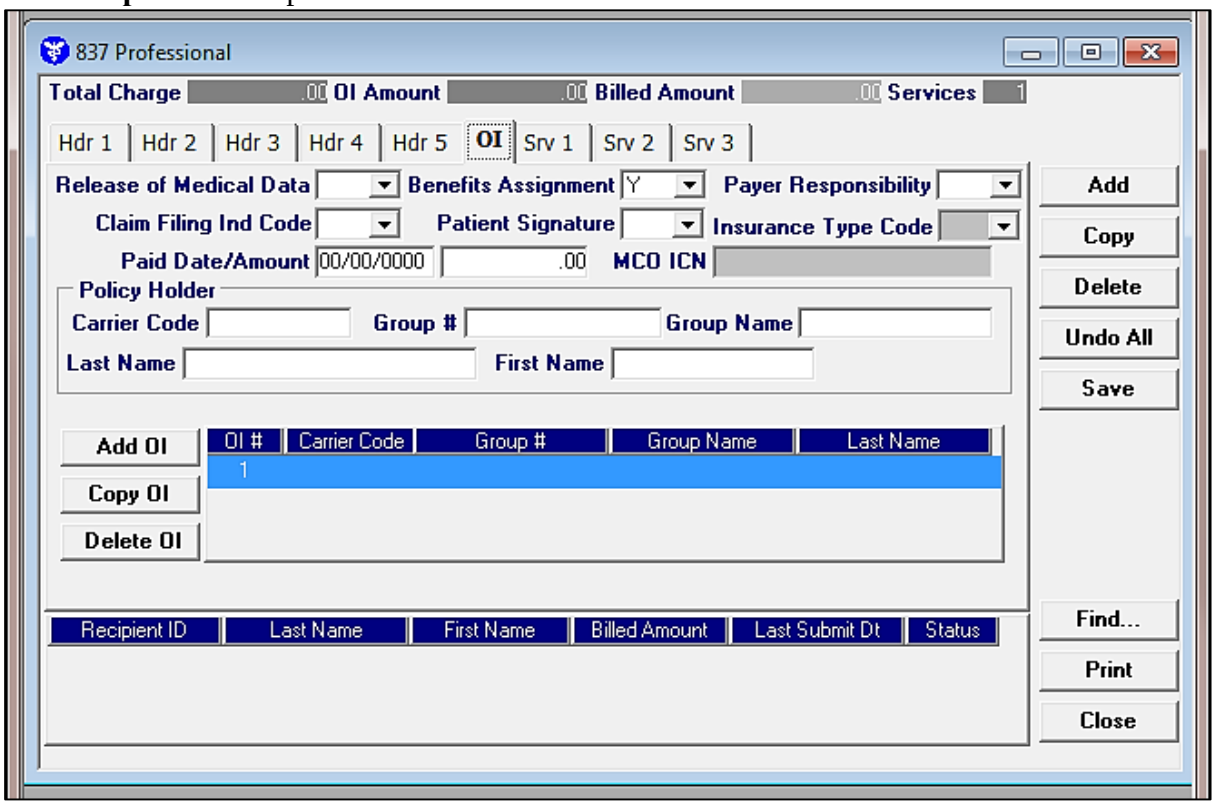
Step 8. Complete Pat.



Patient ID	Enter the 10-digit recipient ID for the newborn. If the recipient ID is not known, leave this field blank; this value will automatically populate with the mother's recipient ID number when the claim is submitted.
Last Name	Enter the last name for the recipient.
First Name	Enter the first name for the recipient.
MI	Enter the recipient's middle initial.
Date of Birth	Enter the date of birth of the newborn using the 2-digit month, 2-digit day, and 4-digit year format (MMDDYYYY).
Date of Death	Enter the date of death of the newborn, if applicable. Use the 2-digit month, 2-digit day, and 4-digit year format (MMDDYYYY).
Gender	Select the gender of the recipient from the drop down list, or enter an appropriate value, as specified:

	M – Male **F** – Female **U** – Unknown

Step 9. Complete Other Insurance.


837 Professional
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 OI Srv 1 Srv 2 Srv 3
Release of Medical Data Benefits Assignment Y Payer Responsibility
Claim Filing Ind Code Patient Signature Insurance Type Code
Paid Date/Amount 00/00/0000 .00 MCO ICN
Policy Holder
Carrier Code Group # Group Name
Last Name First Name
Add OI
Copy OI
Delete OI
OI # Carrier Code Group # Group Name Last Name
1
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

Release of Medical Data	Select the appropriate release code from the drop down list, or enter an appropriate value as specified: Select **I** – Informed Consent to Release Medical Information-Use for conditions or diagnosis regulated by Federal statutes. Select **Y –** Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim – Use if the provider has a signed statement on file that permits the release of medical data to other organizations.
Benefits Assignment	Select the assignment code from the drop down list, or enter an appropriate value as specified. Select **Y –** Yes - Recipient or authorized person has authorized that benefits be assigned to the provider. Select **N –** No - Recipient or authorized person has authorized that benefits be assigned to the provider. Select **W** – for Not Applicable – Not applicable for this claim.

<table>
<tr><td>Payer Responsibility</td><td colspan="2">Level of payer responsibility for the recipient’s other insurance.
Select the appropriate code from the drop down list, or enter an appropriate value as specified:
P – Payer 1
S – Payer 2
T – Payer 3
A – Payer 4
B – Payer 5
C – Payer 6
D – Payer 7
E – Payer 8
F – Payer 9
G – Payer 10
H – Payer 11
U – Unknown</td></tr>
<tr><td rowspan="2">Claim Filing Indicator Code</td><td colspan="2">Select the claim code from the drop down list, or enter an appropriate value as specified. The claim code identifies the type of other insurance claim that is being submitted:</td></tr>
<tr><td>MC – Medicaid
11 – Other Non – Federal Program
12 – Preferred Provider Organization (PPO)
13 – Point of Sale (POS)
14 – Exclusive Provider Organization (EPO)
15 – Indemnity Insurance
16 – Health Maintenance Organization (HMO) Medicare Risk
17 – Dental Maintenance Organization
AM – Automotive Medical
BL – Blue Cross/ Blue Shield</td><td>CH – CHAMPUS
CI – Commercial Insurance Co.
DS – Disability
FI – Federal Employees Program
HM – Health Maintenance Organization
LM – Liability Medical
MA – Medicare A
MB – Medicare B
OF – Other Federal Program
TV – Title V
VA – Veterans Administration Plan
WC – Worker’s Compensation Health Claim
ZZ – Mutually Defined</td></tr>
</table>

Patient Signature	Select the signature code from the drop down list, or enter an appropriate value as specified. The signature code identifies how a recipient's or authorized person's signature was obtained, and how it is retained by the provider. **P** – Signature generated by provider because the patient was not physically present for service
Insurance Type Code	The window is only active if the payer is Medicare with Claim filing code of MB and the Payer Responsibility is not P (Primary). Select the appropriate value from the dropdown box, or enter an appropriate value as specified that identifies the type of insurance listed. **12** – Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan **13** –Medicare Secondary, End-Stage Renal Disease in the Mandated Coordination Period with an Employer's Group Health Plan **14** – Medicare Secondary, No-fault Insurance including Auto is Primary **15** – Medicare Secondary, Worker's Compensation **16** – Medicare Secondary Public Health Service (PHS) or Other Federal Agency **41** – Medicare Secondary Black Lung **42** – Medicare Secondary Veteran's Administration **43** – Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) **47** – Medicare Secondary, Other Liability Insurance is Primary
Paid Date/Amount	This field is divided into two segments. In the left segment of the field, enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient's third party insurance carrier adjudicated the claim. For example, enter 10012015 if the date was October 1, 2015. Enter the amount paid by the other insurance carrier in the right segment of the field, using a decimal point. For example, enter 100.75 if the paid amount was $100.75.
MCO ICN	The MCO ICN field contains the internal claim number assigned to the claim when the managed care organization processed the claim from a provider. Consolidated Community Reporting for OMHSAS (CCR) submitters must enter a MCO ICN. **Note:** The MCO ICN field is activated when "RP" is indicated on Hdr 2 AND has a payer on the OI tab with Claim

	Filing Indicator code "HM". Without these conditions being met, the MCO ICN field will remain disabled.
Carrier Code	Resource code that identifies the third party insurance carrier. This field is automatically populated after you select a Group Number from the Group # field.
Group #	Select the group number for the third party insurance from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.
Group Name	Name of the group or business that makes the insurance available to the insured person. This is **not** the third party insurance group number from the Group **#** field.
Last Name	Policyholder's last name. This field is automatically populated after you select a group number from the Group # field.
First Name	Policyholder's first name. This field is automatically populated after you select a group number from the Group # field.

Each professional claim can have as many other insurance lines as needed. Each other insurance line contains the data fields described in this step.

Step 9.1 Click Add OI to add another other insurance line.

A new blank service line is added to the screen.

Step 9.2 Click on the new line and then enter the other insurance data in the appropriate data fields.

Step 9.3 Click on the existing line of other insurance information you want to copy to a new line.

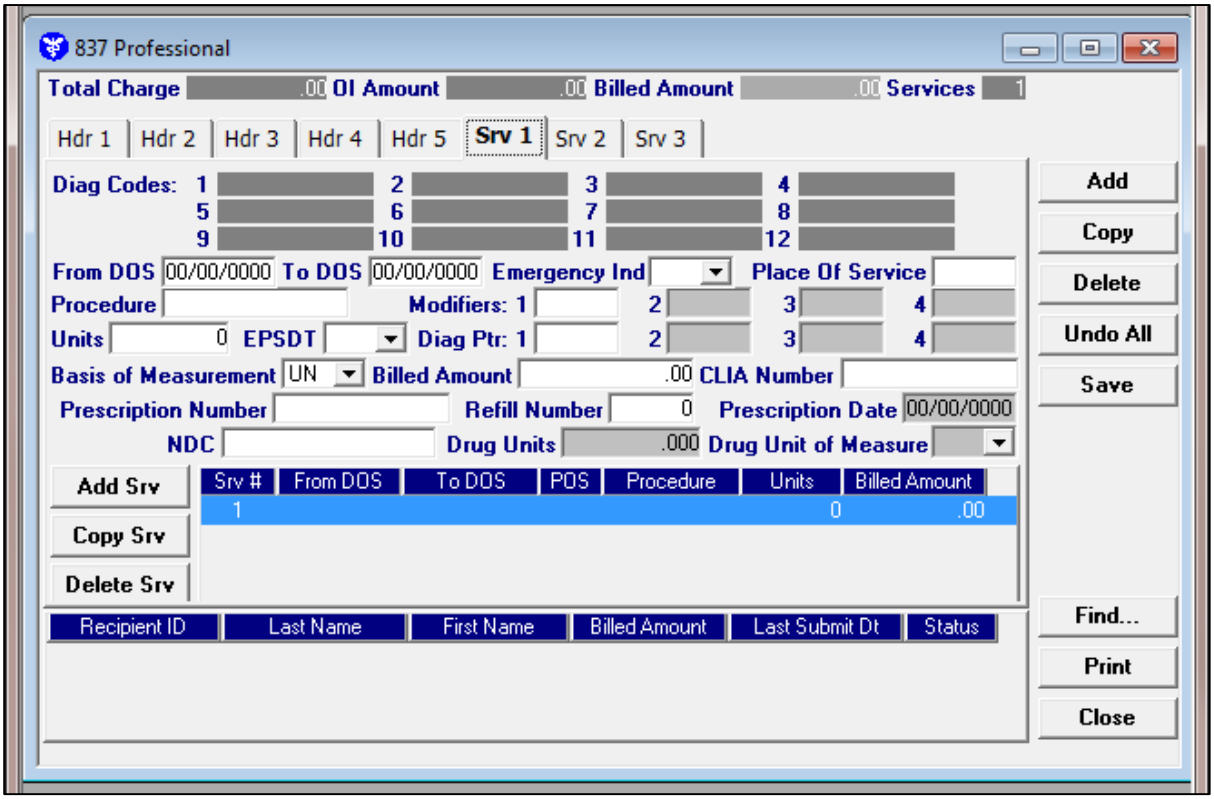
Step 9.4 Click Copy OI. A new insurance line is added to the screen.

The new line has the same data as the existing line that you previously selected. You can edit the data in the new line.

Step 9.5 Click on the new line to edit the data or make changes to the appropriate fields.

Step 9.6 Click Delete OI to delete an existing other insurance line.

Step 10. Complete Service 1.


837 Professional
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Hdr 1 Hdr 2 Hdr 3 Hdr 4 Hdr 5 Srv 1 Srv 2 Srv 3
Diag Codes: 1 2 3 4
5 6 7 8
9 10 11 12
From DOS 00/00/0000 To DOS 00/00/0000 Emergency Ind Place Of Service
Procedure Modifiers: 1 2 3 4
Units 0 EPSDT Diag Ptr: 1 2 3 4
Basis of Measurement UN Billed Amount .00 CLIA Number
Prescription Number Refill Number 0 Prescription Date 00/00/0000
NDC Drug Units .000 Drug Unit of Measure
Add Srv
Copy Srv
Delete Srv
Srv # From DOS To DOS POS Procedure Units Billed Amount
1 0 .00
Recipient ID Last Name First Name Billed Amount Last Submit Dt Status
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

From DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient first received service under this claim. For example, enter 10012015 if the date was October 1, 2015. If the same service was provided on consecutive days, enter the first day of the service in this field and the last day of service in the To DOS field. If you are billing for a service that was provided on only one day, complete the From DOS with the date of service and press the **Tab** key. The same date will populate automatically in the To DOS field. **Note:** The From DOS and To DOS fields are used to determine the Days Supply if being used by a Dispensing Provider.
To DOS	Enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient last received service under this claim. For example, enter 10012015 if the date was October 1, 2015.
Emergency Indicator	Select the emergency code from the drop down list, or enter an appropriate value as specified. Select **Y** — if the service provided was emergency related.

<table>
<tr><td rowspan="2">Place Of Service</td><td colspan="2">Select the place of service code from the drop down list, or enter an appropriate value as specified. This field identifies the location where the service was performed. The only place of service codes accepted on an 837 Professional are:</td></tr>
<tr><td>03 – School
04 – Homeless Shelter
11 – Office
12- Patient’s Home
15 – Mobile Unit
21 – Inpatient Hospital
22 – Outpatient Hospital
23 – Emergency Room-Hospital
24 –Ambulatory Surgical Center ASC/SPU
25 – Birthing Center
26 – Military Treatment Center
31 – Skilled Nursing Facility
32 - Nursing Facility
33 – Custodial Care Facility
34 – Hospice
35 – Adult Living Care Facility
41 – Ambulance – Land
42 – Ambulance – Air or Water
50 – Federally Qualified Health Center</td><td>51 – Inpatient Psychiatric Facility
52 – Psychiatric Facility – Partial Hospitalization
53 – Community Mental Health Care
54 – Intermediate Care Facility/Mentally Retarded ICF/MR
55 – Residential Substance Abuse Treatment Facility
56 – Psychiatric Residential Treatment Center(Non-JCHAO)
60 – Mass Immunization Center
61 – Comprehensive Inpatient Rehabilitation Facility
62 – CORF - Comprehensive Outpatient Rehabilitation Facility
65 – End Stage Renal Disease Treatment Facility
71 – State of Local Public Health Clinic
72 – Rural Health Clinic
81 – Independent Laboratory
99 – Other Unlisted Facility</td></tr>
<tr><td>Procedure</td><td colspan="2">Select the procedure code from the drop down list, or enter an appropriate value as specified. The procedure code identifies the service that was rendered to the recipient.</td></tr>
<tr><td>Modifiers</td><td colspan="2">Enter the 2-digit modifier for the procedure code entered in the Procedure field if the MA Program Fee Schedule indicates that the procedure code requires a modifier.</td></tr>
</table>

Units	Enter the number of units provided to the recipient for the service being billed. For example, enter **1**, if one unit was provided to the recipient. Zero units is an appropriate value.
EPSDT	Select the EPSDT code from the drop down list, or enter an appropriate value as specified. Select **Y** – if the recipient is part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.
Diag Ptr	The field number of the Diagnosis Codes field on the Header 2 screen contains the detailed diagnosis number for the diagnosis that relates to this service. Enter that field number here using one numeric character.
Basis of Measurement	Select the basis code from the drop down list, or enter an appropriate value as specified. The basis code identifies the units in which a value is being expressed, or the manner in which a measurement has been taken. **MJ** – Minutes (Professional) **UN** – Unit (Institutional and Professional)
Billed Amount	Enter the usual charge to the self-paying public for the service(s) provided, using a decimal point. If billing for multiple units, multiply the usual charge by the number of units billed and enter that amount. A zero billed amount is an appropriate value.
CLIA Number	Enter the CLIA Number that identifies the certified facility that performed the CLIA-covered laboratory services. This field is required for any laboratory that performs tests covered by the CLIA Act.
Prescription Number	Enter the prescription number that identifies the prescription. If the prescription number is less than 12 numeric characters, add zeroes to the beginning of the prescription number to make it equal to 12 characters. (ex. 000000001234) **Note:** Required if being used by Dispensing Provider.
Refill Number	Enter the refill number if a prescription is refilled. This field accepts one numeric character. **Note:** Required if being used by Dispensing Provider.
Prescription Date	Date Expressed in Format CCYYMMDD - Required when a drug is billed for this line and a prescription was written. **Note:** Required if being used by Dispensing Provider.

NDC	If dispensing medication, enter the NDC number in this field, using the 5-4-2 format. Zero-fill to complete the 5-4-2 format. Enter the zeroes in the beginning of the segment. (Ex: 00123-0123-01. *Dashes are not required in the field, but are shown for clarity*). **If you are dispensing medication, you will need to create a separate claim for the administration procedure.** **Note:** Required if being used by Dispensing Provider.
Drug Units	The actual count of Milliliters, Grams, or Units of a dispensed drug. **Note:** Required if being used by Dispensing Provider.
Drug Unit of Measure	Select the value from the drop down box, or enter an appropriate value as specified: **GR** – Gram **ML** Milliliter **UN** - Unit **Note:** Required if being used by Dispensing Provider.

Step 10.1 Click Add Srv to add another service line.

A new blank service line is added to the screen.

Step 10.2 Click on the new service line, and then enter the service data in the appropriate data fields.

Step 10.3 Click on the existing service line that contains information you want to copy to a new service line.

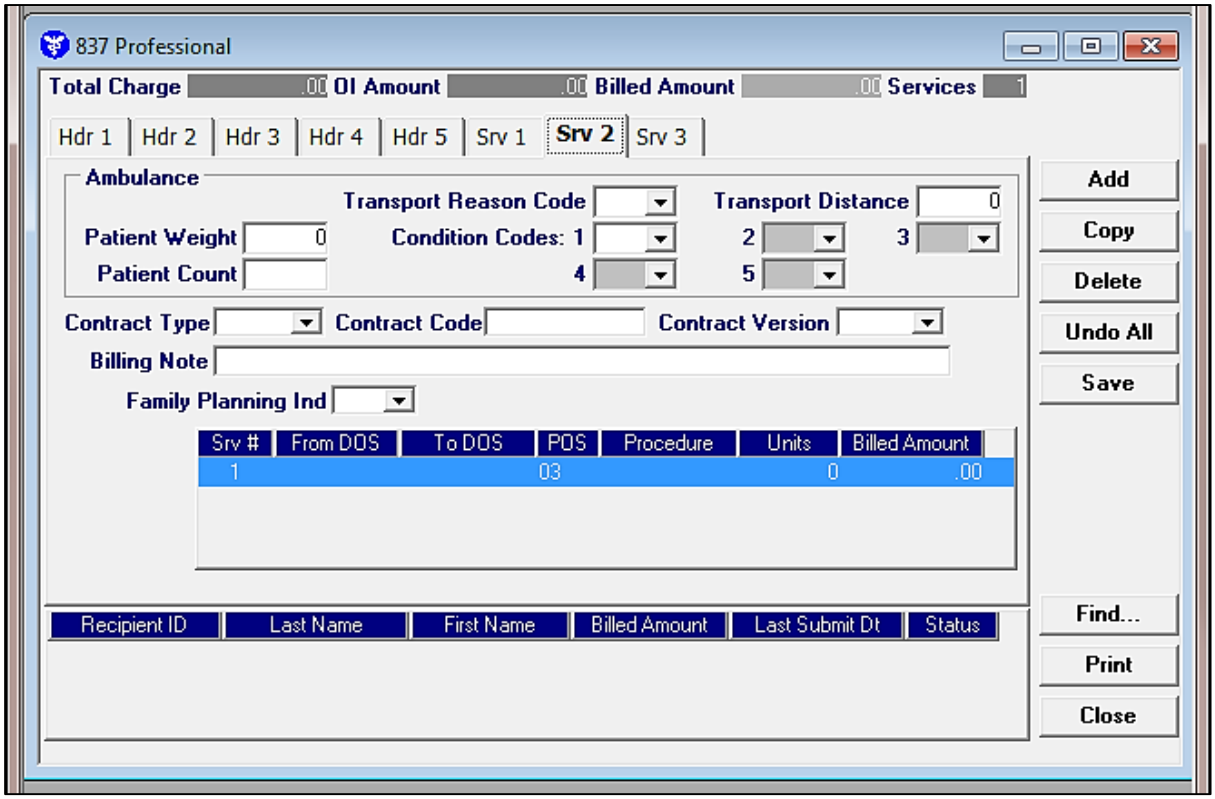
Step 10.4 Click Copy Srv to add a new service line to the screen.

The new service line has the same data as the existing service line you previously selected. You can edit the data in the new service line. Simply click on the new service line and make changes to the appropriate fields.

Step 10.5 Click on the service line that you want to delete, and then click Delete Srv to delete an existing service line.

The selected service line is deleted.

Step 11. Complete Service 2.



Transport Reason Code (Ambulance)	Select the transport reason code from the drop down list, or enter an appropriate value as specified: **A** – Patient was transported to the nearest facility for care of symptoms, complaints, or both **B** – Patient was transported for benefit of a preferred physician **C** – Patient was transported for the nearness of family members **D** – Patient was transported for the care of a specialist or specialized equipment **E** – Patient was transported to Rehabilitation Facility.
Transport Distance (Ambulance)	Enter the number of miles the recipient was transported by ambulance.
Patient Weight (Ambulance)	Enter the weight of the patient, in pounds, at the time of transport by ambulance.
Condition Codes (Ambulance)	Select the appropriate code from the drop down list, or enter an appropriate value as specified: **01** – Patient was admitted to a hospital

	04 – Patient was moved by stretcher **05** – Patient was unconscious or in shock. **06** – Patient was transported in an emergency situation **07** – Patient had to be physically restrained **08** – Patient had visible hemorrhaging **09** – Ambulance service was medically necessary **12** – Patient is confined to a bed or chair
Patient Count	Required when more than one patient is transported in the same vehicle for Ambulance or non-emergency transportation services.
Contract Type	The indicator represents the contract between the provider and the managed care or sub-capitation subcontractor. Choose a value from the drop-down list. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Code	Enter the appropriate contract code information. The contract number between the provider and the managed care or sub-capitation subcontractor. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR).
Contract Version	Enter the contract number held with DHS. This field is used only by Consolidated Community Reporting for OMHSAS (CCR) submitter. The contract version is the month of the contract that was in force at the time of the service. **Note:** Fee For Service Providers who are billing directly to Medical Assistance do not use this field. For Consolidated Community Reporting for OMHSAS (CCR) Values **01** thru **12**
Billing Note	Enter any appropriate billing notes in this field. (This field is optional.)
Family Planning	Enter the appropriate Family Planning indicator in this field.

Step 11.1 Click

to add another service line.

Step 11.2 A new blank service line is added to the screen.

Step 11.3 Click on the new service line, and then enter the service data in the appropriate data fields.

Step 11.4 Click on the existing service line that contains information you want to copy to a new service line.

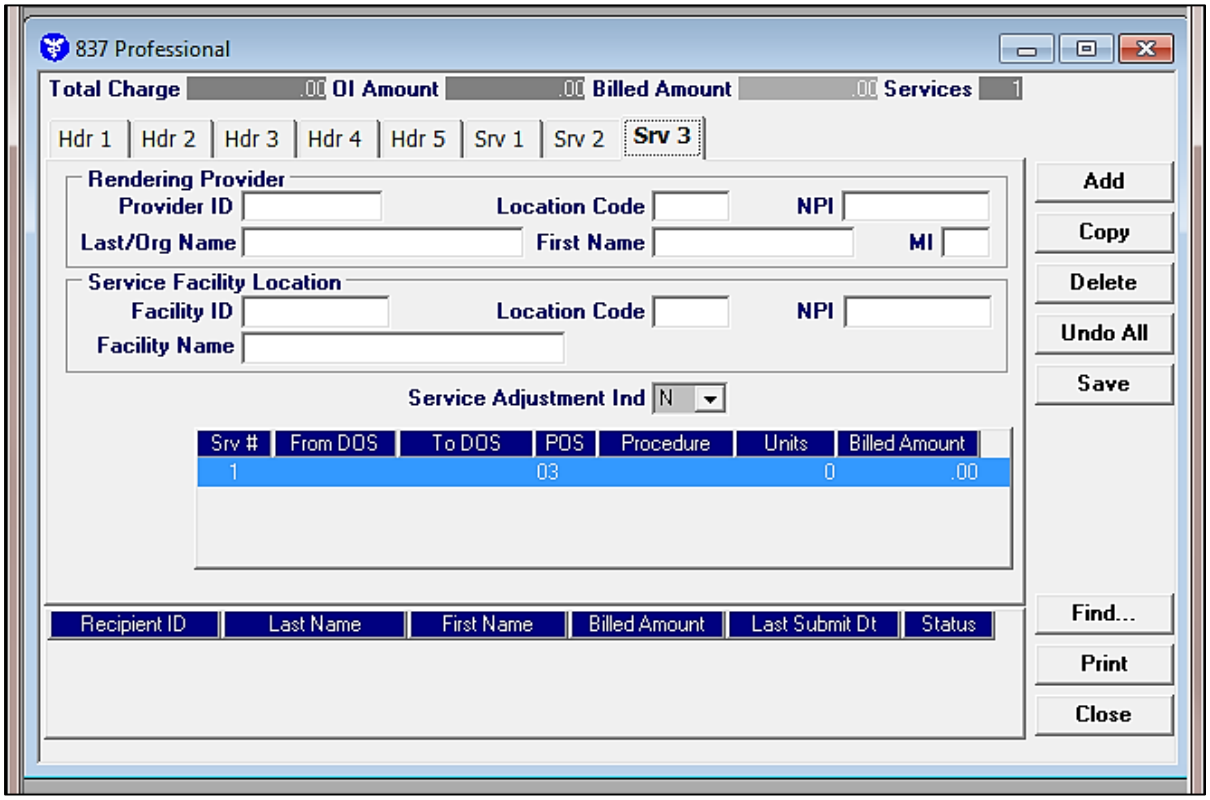
Step 11.5 Click Copy Srv to add a new service line to the screen.

Step 11.6 The new service line has the same data as the existing service line you previously selected. You can edit the data in the new service line. Simply click on the new service line and make changes to the appropriate fields.

Step 11.7 Click on the service line that you want to delete, and then click Delete Srv to delete an existing service line.

Step 11.8 The selected service line is deleted.

Step 12. Complete Service 3.



Provider ID (Rendering Provider)	If the rendering provider is different on the service line than the rendering provider on the claim: Select the 9-digit MPI number from the drop down box. You can also double click in the data entry area in the field to add a reference list selection.

Location Code (Rendering Provider)	Provider's 4- digit service location code associated with the MPI number selected in the Provider ID field. This field is automatically populated when an MPI number is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
NPI (Rendering Provider)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Last/Org Name	Last name of the provider indicated in the Provider ID field. This field is automatically populated when an MPI number is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form*
First Name	First name of the provider indicated in the Provider ID field. This field is automatically populated when an MPI number is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form*
Middle Initial	Middle initial of the provider indicated in the Provider ID field. This field is automatically populated when an MPI number is selected. *Information cannot be entered directly into this field. If you need to add or edit information in this field, access the Provider Form.*
Facility ID (Service Facility Location)	If the services are being ONLY rendered in an inpatient hospital, emergency room, a hospital special treatment room, a hospital short procedure unit, an ambulatory surgical center or a renal dialysis center, select the 9-digit ID Number for the Service Facility Location from the field's pull down list.
Location Code (Service Facility Location)	Enter the 4-digit Service Location Code that corresponds to the Provider Specialty and Address.
NPI (Service Facility Location)	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Facility Name	Enter the last name of an individual provider (when the Entity Type Qualifier is a 1), or the business name of a group or facility

(Service Facility Location**)**	(when the Entity Type Qualifier is a 2). Not all 35 characters will display on the Provider Last Name fields on the Header screens.
Service Adjustment Indicator	Select the adjustment code from the field's drop down list, or enter an appropriate value as specified. Select **Y–** if a third party insurance carrier has made a payment toward the claim. Selecting Y will add the Service Adjustment screen to the form for this claim line. Select **N–** if a third party insurance carrier has not made a payment toward the claim. Service adjustment is defined as an adjustment that is being made to the billed amount by an insurance carrier other than MA. For example, a service adjustment would be completed if a third party insurance carrier either paid a monetary amount toward the claim or denied the claim prior to the claim's submission to MA. If multiple professional service lines were entered on the Service 1 screen, these service lines also appear on the Service 2 screen. Each service line contains the data fields described in this step. Click on a service line to access its data fields. Each service line is linked to a separate Service Adjustment screen. Therefore, it is necessary to complete the Service Adjustment screen for each service line that has received partial payment from a third party insurance carrier. To access the Service Adjustment screen for a particular service line, follow the steps below: • Select the service line you are adjusting from the Service 1 Screen. • Select **Y** in the Service Adjustment Ind field on the Service 3 screen. The Service Adjustment screen is displayed.

Step 12.1 Click

to add another service line.

A new blank service line is added to the screen.

Step 12.2 Click on the new service line, and then enter the service data in the appropriate data fields.

Step 12.3 To copy the data from an existing service line to a new service line, click on the existing service line that contains information you want to copy.

Step 12.4 Click

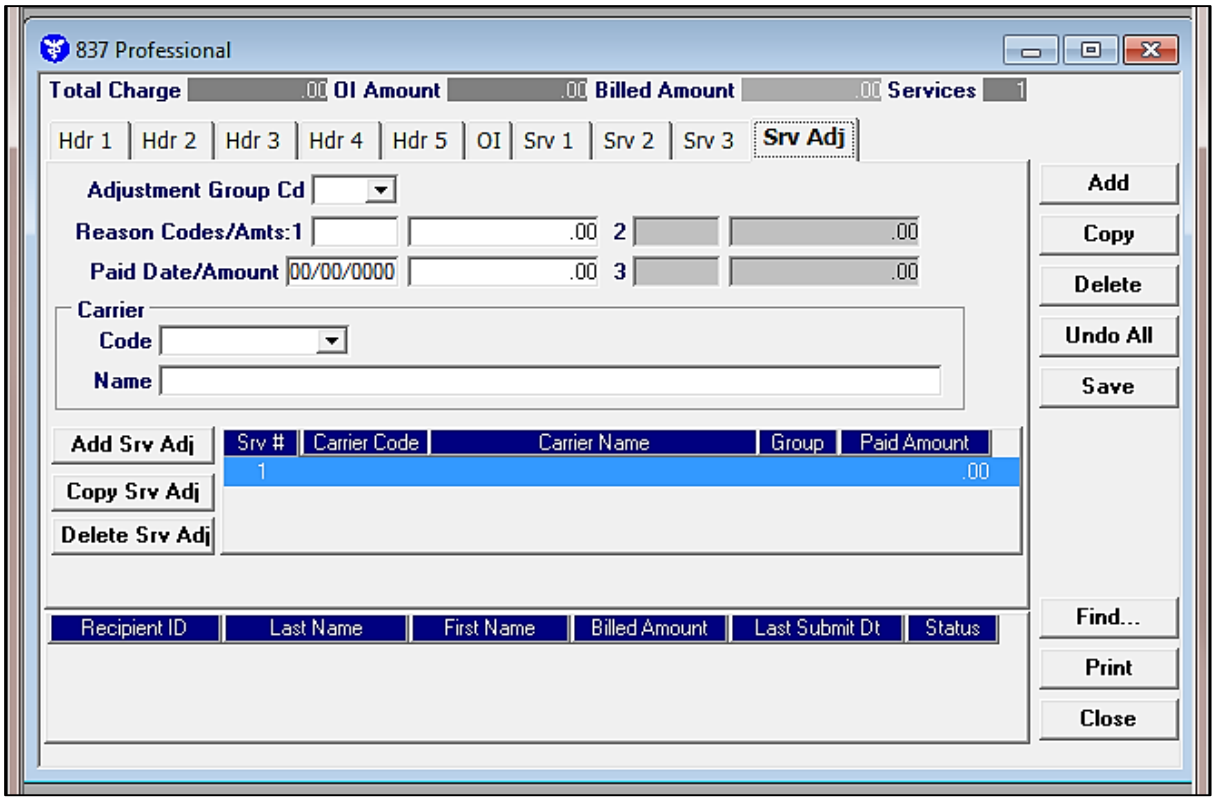
to add a new service line to the screen.

The new service line has the same data as the existing service line you previously selected. You can edit the data in the new service line. Simply click on the new service line and make changes to the appropriate fields.

Step 12.5 To delete an existing service line, click on the service line you want to delete, and then click Delete Srv.

The selected service line is deleted.

Step 13. Complete Service Adjustment.



Step 13.1 Select the service line you want to adjust from the Service 1 screen. This accesses the Service Adjustment screen for a particular service line.

Step 13.2 Select **Y** in the Service Adjustment Ind field on the Service 3 screen.

The Service Adjustment screen populates for the service line previously selected from the Service 1 screen.

Adjustment Group Cd	General category of the adjustment being made to the claim. Select the adjustment group code from the drop down list, or enter an appropriate value as specified:	
	CO – Contractual Obligations **CR** – Correction and Reversals **OA** – Other Adjustments	**PI** – Payer Initiated Reductions **PR** – Patient Responsibility

Reason Codes/Amts, Fields 1-3	Each field is divided into two segments. In the left segment of the field, select the appropriate reason code from the segment's drop down list, or enter an appropriate value as specified. The reason code identifies the reason the adjustment is being made to the claim. **1** – Deductible Amount **118**-ESRD Network Support Adjustment**119** – Benefit Maximum for this time period has been reached **2** – Coinsurance Amount **23** – Payment adjusted because charges were paid by another payer **3** – Copayment Amount **35** – Lifetime Benefits Maximum has been reached **45 -** Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement **50** – Non-covered services Enter the amount of the adjustment in the right segment of the field, using a decimal point. For example, enter 105.50 if the adjustment amount was $105.50.
Paid Date/Amount	Field is divided into two segments. In the left segment of the field, enter the 2-digit month, 2-digit day, and 4-digit year on which the recipient's third party insurance carrier paid the claim. For example, enter 10012015 if the date was October 1, 2015. Enter the amount paid by the other insurance carrier in the right segment of the field, using a decimal point. For example, enter 105.50 if the paid amount was $105.50. An amount of 0 may be entered. If the third party insurance carrier paid $0.00, complete the Paid Date/Amount field with the date of third party insurance explanation of benefits (EOB) denial and the amount of 0.00. If Medicare is the third party insurance carrier, complete this field using the Medicare Approved amount.
Code (Carrier)	Select the carrier code from the drop down list, or enter an appropriate value as specified. The carrier code identifies the recipient's third party insurance carrier. The list consists of the NEIC codes for insurance carriers.

Name (Carrier)	Name of the recipient's third party insurance carrier. This field automatically populates after you select a carrier code in the Code field.

Each professional claim can have unlimited adjustment lines. Each claim line contains the data fields described in this step.

Step 13.3 Click Add Srv Adj to add another claim adjustment line.

A new blank claim line is added to the screen.

Step 13.4 Click on the new claim line, and then enter the claim adjustment data in the appropriate data fields.

Step 13.5 Click on the existing line you want to copy, and then click Copy Srv Adj to copy the data from an existing claim adjustment line to a new adjustment line.

A new line is added to the screen. This new line has the same data as the existing adjustment line previously selected. Edit the data in the new line.

Step 13.6 Click on the new adjustment line and make changes to the appropriate fields.

Step 13.7 Click Delete Srv Adj to delete an existing claim adjustment line.

The selected line is deleted.

Service adjustment lines are linked to the claim line that is highlighted when you access the service adjustment screen. Make sure you highlight the correct service line for the service adjustment you are entering.

Step 14. Click Save to save the professional claim.

Step 15. Click Close to exit the 837 Professional Form.

9.9 Complete an NCPDP Pharmacy Claim Form

Note: The valid values listed are using the External Code List (ECL) published March 2010. The valid values will be updated annually in October and will include any ECL published in the prior calendar year.

The NCPDP Pharmacy Form is used to submit drug claims by Retail Pharmacies. The NCPDP Pharmacy Form is divided into six screens. Each screen contains:

Header	Screen contains information related to the pharmacy that dispensed the medication and the recipient to whom the prescription is provided.
Patient	Screen contains information related to the Patient.
Claim 1	Screen contains the prescription information.

Claim 2	Screen contains additional prescription information, including responses to any drug therapy issues that have been identified when the claim was previously submitted.
Prescriber	Screen contains Prescriber Information
Coupon	Screen contains Coupon information.
Clinical 1	Screen contains clinical information related to the claim.
Clinical 2	Screen contains clinical information related to the claim.
Compound	Screen contains information regarding compound claims.
COB 1 (Coordination of Benefits)	Screen contains information related to the reimbursement received from other payers.
COB 2 (Coordination of Benefits)	Screen contains information related to the reimbursement received from other payers.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

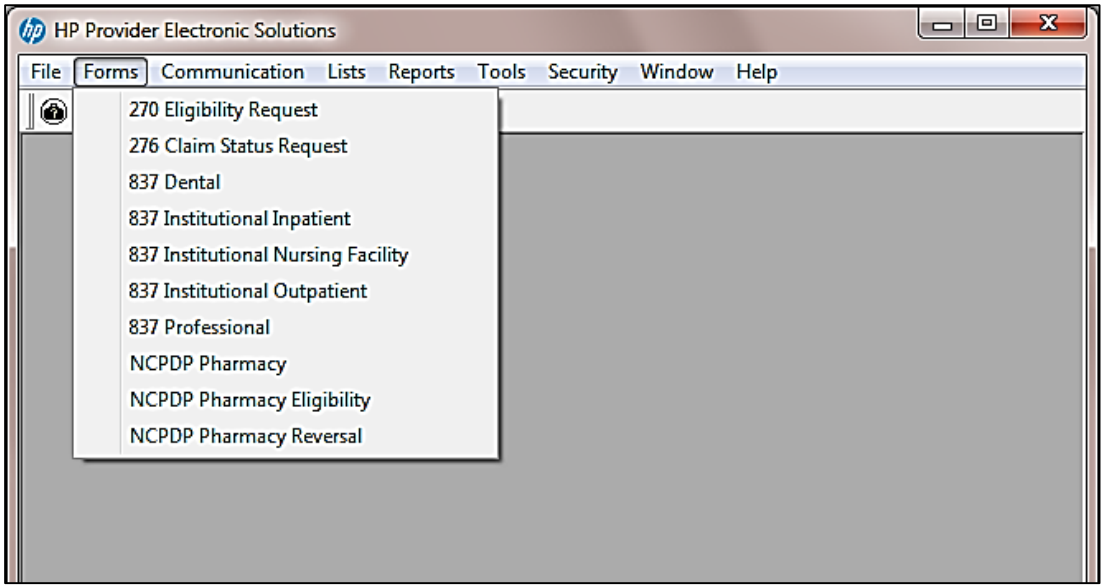
To create a pharmacy claim, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, access the NCPDP Pharmacy Form in one of two ways:

Click (NCPDP Pharmacy Shortcut icon) on the Toolbar

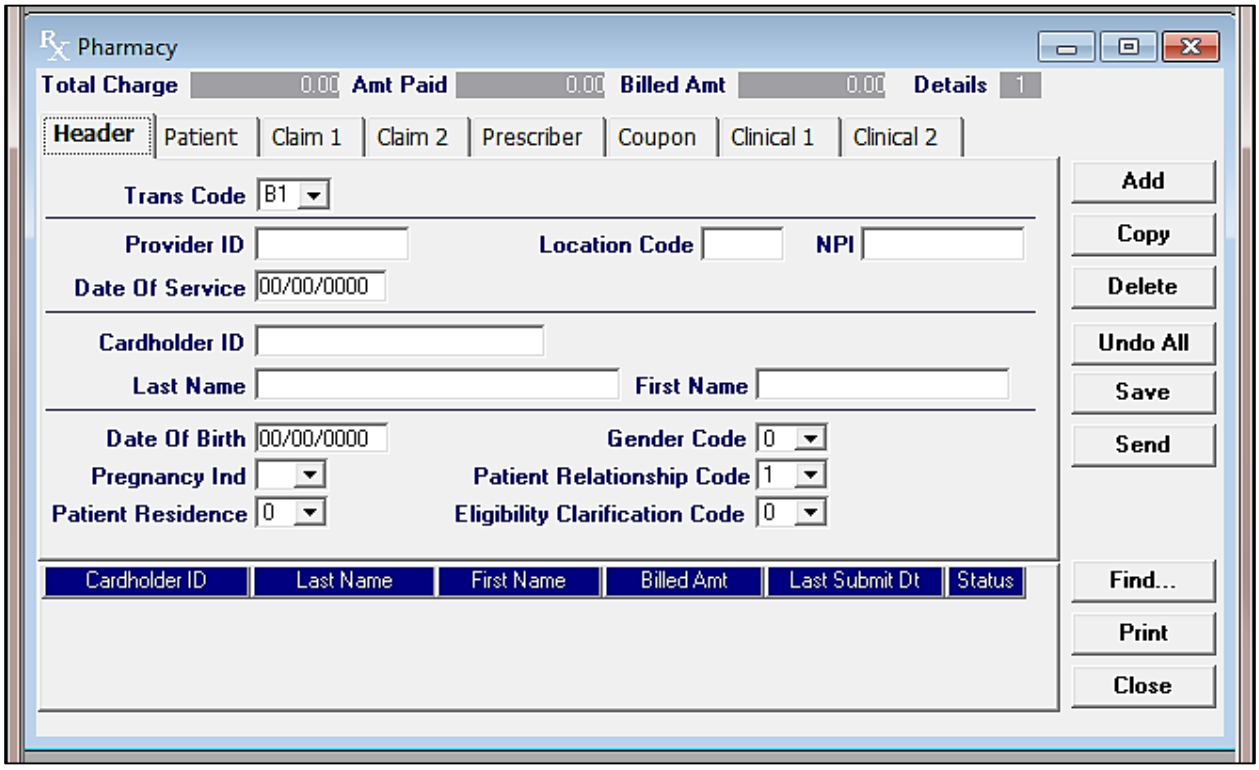
or

Select the **NCPDP Pharmacy** option from the **Forms** drop down menu.



The NCPDP Pharmacy Form appears, with the Header screen displayed.

Step 2. Complete Header 1.



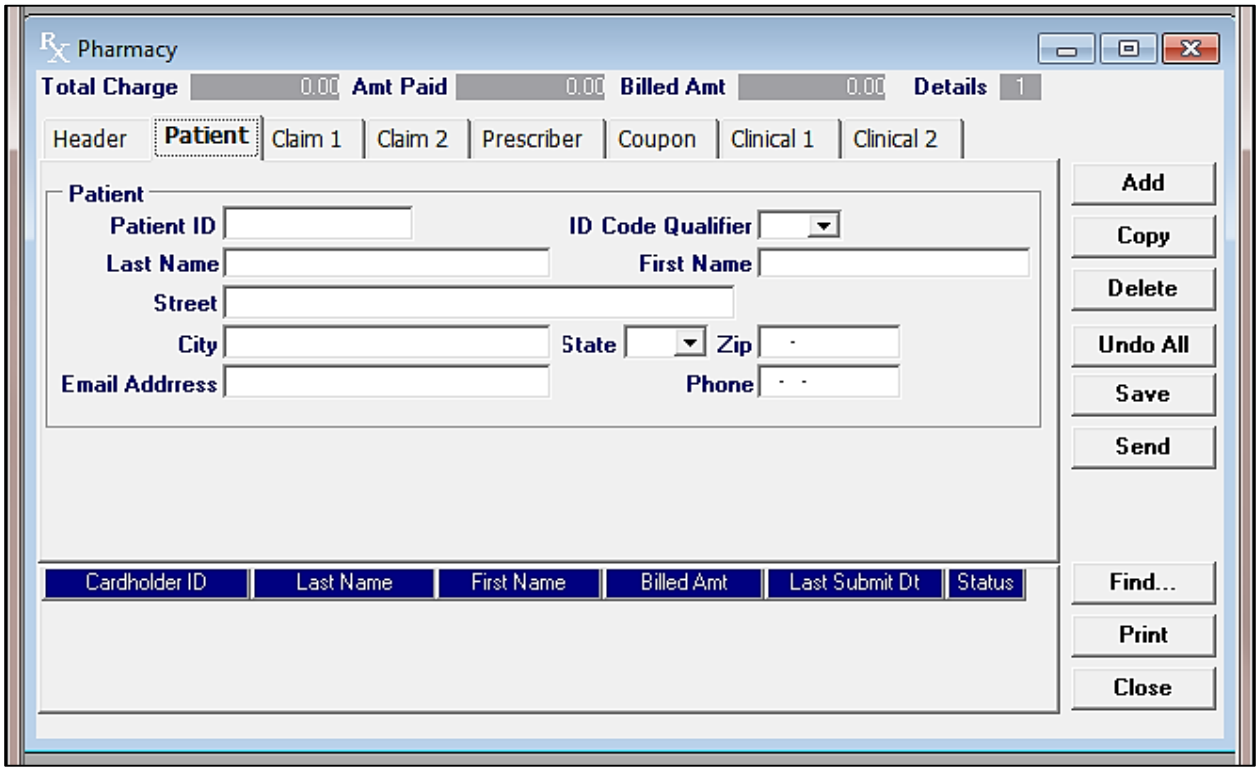
Trans Code	Select the Trans Code from the drop down list, or enter an appropriate value as specified.

	Select **B1** for a new billing. Select **B3** for a rebill.
Provider ID	Select the 9-digit MPI number for the payee from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. This is the provider MPI number under which the claim will be paid.
Location Code	The 4-digit location code associated with the selected 9-digit MPI number. This field automatically populates after you select a provider ID. Pharmacists who qualify as a Qualified Small Business (QSB) should add a **Q** as the fifth character in the Location Code.
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Date Of Service	Enter the 2-digit month, 2-digit day and 4-digit year on which the service was provided. For example, enter 01012015 if the date was January 1, 2015.
Cardholder ID	Select the Cardholder ID number from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. Cardholder ID numbers are issued to recipients who are authorized to receive Pennsylvania Medicaid services. (Cardholder IDs consist of the 10-digit recipient ID number, and the 2-digit card issue number.)
Last Name	Cardholder's (recipient's) last name. (Use this field only if you enter the data when you enter the cardholder ID number.)
First Name	Recipient's first name.
Date of Birth	The date the Policy Holder was born. Field is in the format MM/DD/CCYY.
Gender Code	Select from the drop down box: **0** – Not Specified **1** – Male **2** - Female
Pregnancy Indicator	Select the pregnancy code from the drop down list, or enter an appropriate value as specified.

	Not Specified Select **1** – if the recipient is not pregnant. Select **2** – if the recipient is pregnant.
Patient Relationship Code	Select the code from the drop down list, or enter an appropriate value as specified. **0** – Not Specified **1** – Cardholder **2** – Spouse **3** – Child **4** - Other
Patient Residence	Select the patient location code from the drop down list, or enter an appropriate value as specified. This code identifies the location of the recipient when receiving pharmacy services. The only Patient Location codes that are accepted by MA are: **00 –** Not Specified **1** – Home **2 –** Skilled Nursing Facility **3 –** Nursing Facility **4 –** Assisted Living Facility **5 –** Custodial Care facility **6** – Group Home **7** – Inpatient Psychiatric Facility **8** – Psychiatric Facility **9** – Intermediate Care Facility (ICFMR) **10** – Residential **11 -** Hospice **12 –** Psychiatric Residential Facility **13** – Comprehensive Inpatient Facility **14** – Homeless Shelter **15** – Correctional Institution

Eligibility Clarification Code	Select the eligibility clarification code from the drop down list, or enter an appropriate value as specified. This code indicates that the pharmacy is clarifying eligibility based on the receipt of a denial. **0** – Not specified **1** – No Override **2** – Override **3** – Full Time Student **4** – Disabled Dependent **5** – Dependent Parent **6** – Significant Other

Step 2.1 If Patient Relationship Code is anything other than 0 (Not Specified) the Patient tab will be required.



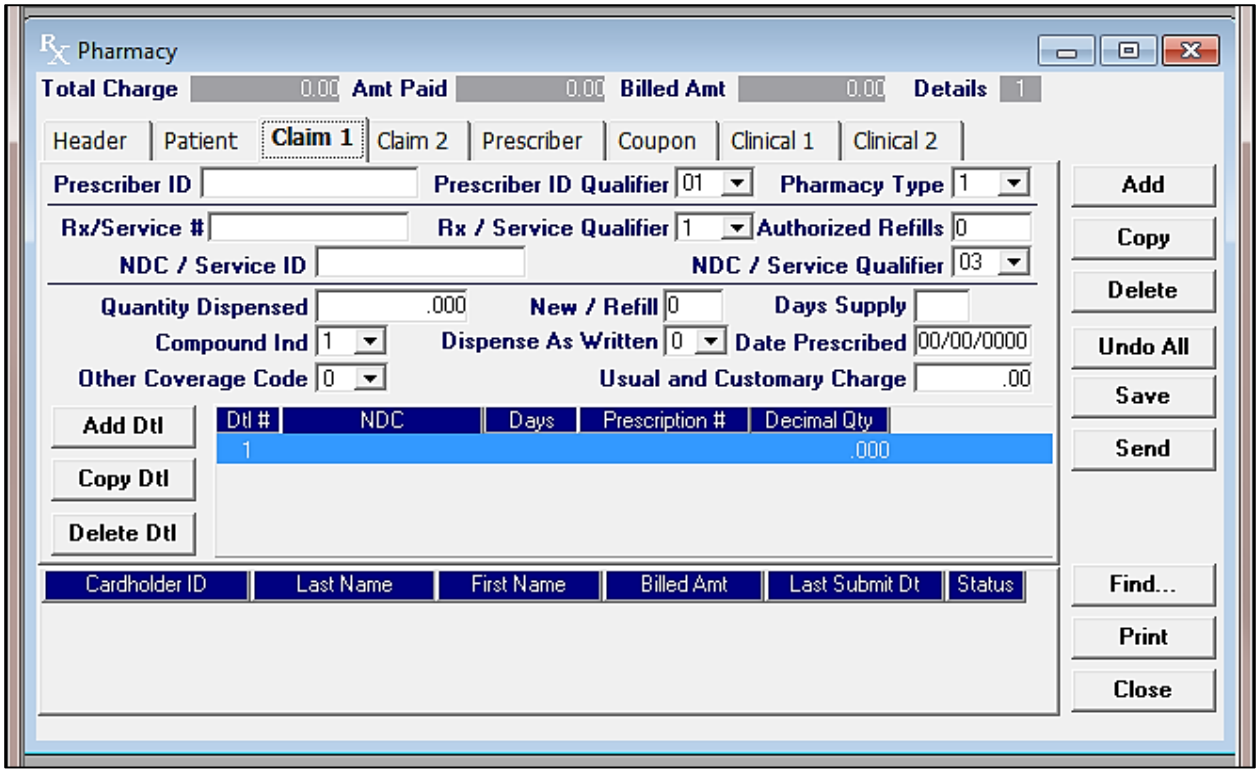
Patient ID	Enter the identification number issued to recipients who are authorized to receive Pennsylvania Medicaid services.
ID Qualifier	This field identifies the type of number used in the Patient ID field. [i.e. Medicaid ID Number, Client ID Number, Member ID Number, Insurance Policy Number or Social Security Number. Select the appropriate code. For NCPDP claims this value should always be blank.

	Select a value from the drop down box or enter an appropriate value as specified. **01-** Social Security Number **02-** Driver's License Number **03-** US Military ID **04-** Non-SSN-Based Patient Identifier **05-** SSN- Based Patient Identifier **06-** Medicaid ID **07-** State Issued ID **08-** Passport ID **09-** Medicare HIC # **10-** Employer Assigned ID **11-** Payer/PBM Assigned ID **12-** Alien Number **13-** Government Student Visa Number **14-** Indian Tribal ID **1J**-Facility ID Number **99**-Other **EA**-Medical Record Identification Num
Last Name	Patient's last name
First Name	Patient's last name
Street	Street Address of the Patient
City	City where the Patient resides
State	State where the Patient resides
Zip	Patient's zip code. Enter all 9 digits.
Email Address	Patient's Email address
Phone	Patient's phone number include the area code.

Step 2.2 Click the Claim 1 tab to access the Claim 1 screen.

The Claim 1 screen is displayed.

Step 3. Complete Claim 1.



Prescriber ID	Enter the 8- or 9-character prescriber's license number. The formats for medical license numbers are AAXXXXXXA, AAXXXXXX, or AAAXXXXXX, where A is an alpha character, and X is a numeric character.
Prescriber ID Qualifier	Qualifier code for the prescriber ID number. The qualifier code must always be **08** to indicate that the state license number has been entered.
Pharmacy Type	Select the code from the drop down list or enter an appropriate value as specified. **1** – Community/Retail Pharmacy Services **2** – Compounding Pharmacy Services **3** – Home Infusion Therapy Services **4** – Institutional Pharmacy Services **5** – Long Term Care Pharmacy Services **6** – Mail Order Pharmacy Services **7** – Managed Care Organization Services **8** – Specialty Care Pharmacy Services **99** - Other

RX / Service #	Enter the prescription ID number of the prescription that was filled. If the prescription number is less than 12 numeric characters, add zeroes to the beginning of the prescription number to make it equal to 12 characters. (ex. 000000001234)
Rx / Service Qualifier	Select the qualifier code from the drop down list, or enter an appropriate value as specified. The qualifier code must always be **1** for NCPDP claims.
Authorized Refills	Enter a number to indicate how many times this prescription can be filled. Zero indicates Not Specified.
NDC/ Service ID	Select the 11-digit NDC for the product that was dispensed. If the compound indicator field contains the value **2**, then the NDC/Service ID must be **0**. If the compound indicator field contains the value **0** or **1**, then the 11-digit NDC for the drug dispensed must be entered.
NDC / Service Qualifier	Qualifier code for the NDC. The qualifier code must always be **03** for claims.
Quantity Dispensed	Enter the quantity being dispensed, expressed in metric decimal units.
New / Refill	Enter a number to indicate whether the prescription is the original prescription or a refill. Enter **0** to indicate that this is the first time the prescription is filled.
Days Supply	Enter the number of days the dispensed quantity should last.
Compound Ind	Select the compound code from the drop down list, or enter an appropriate value as specified. This compound code identifies if the prescription is a compound. **1** – Not a Compound **2** - Compound
Dispense As Written	Enter the appropriate code, or enter an appropriate value as specified that indicates whether the prescriber's instructions regarding generic substitution have been followed. **0** – No Product Selection Indicated **1** – Substitution Not Allowed by Prescriber **2** – Substitution Allowed – Patient Requested Product Dispensed **3** - Substitution Allowed – Pharmacist Selected Product Dispensed **4** - Substitution Allowed – Generic Drug Not in Stock **5** - Substitution Allowed – Brand Drug Dispensed as Generic

	6 – Override **7** - Substitution Not Allowed – Brand Drug Mandated by Law **8** - Substitution Allowed – Generic Drug Not Available in Marketplace **9** – Substitution Allowed by Prescriber
Date Prescribed	Enter the 2-digit month, 2-digit day, and 4-digit year on which the prescription was written. For example, enter 01012015 if the date was January 1, 2015.
Other Coverage Code	Select the other coverage code from the drop down list, or enter an appropriate value as specified. This code indicates if the recipient has other drug coverage. The default value for this field is **00**. If you select **02**, the COB screen appears. **00** – Not Specified **01** – No Other Coverage **02** – Other Coverage Exists – Payment Collected **03** - Other Coverage Exists – Claim Not Covered **04** - Other Coverage Exists – Payment Not Collected **08** – Claim is Billing for Patient Responsibility (Copay)
Usual and Customary Charge	Enter the amount charged to cash customers for the prescription, exclusive of sales tax or other amounts claimed. This value should include a decimal point.

Step 3.1 Click Add Dtl to add another detail line,

A new blank detail line is added to the screen.

Step 3.2 Click on the new detail line, and then enter the data in the appropriate data fields.

Step 3.3 Click Copy Dtl to copy the data from an existing detail line to a new detail line.

A new detail line is added to the screen.

The new detail line has the same data as the existing detail line you previously selected. You can edit the data in the new detail line.

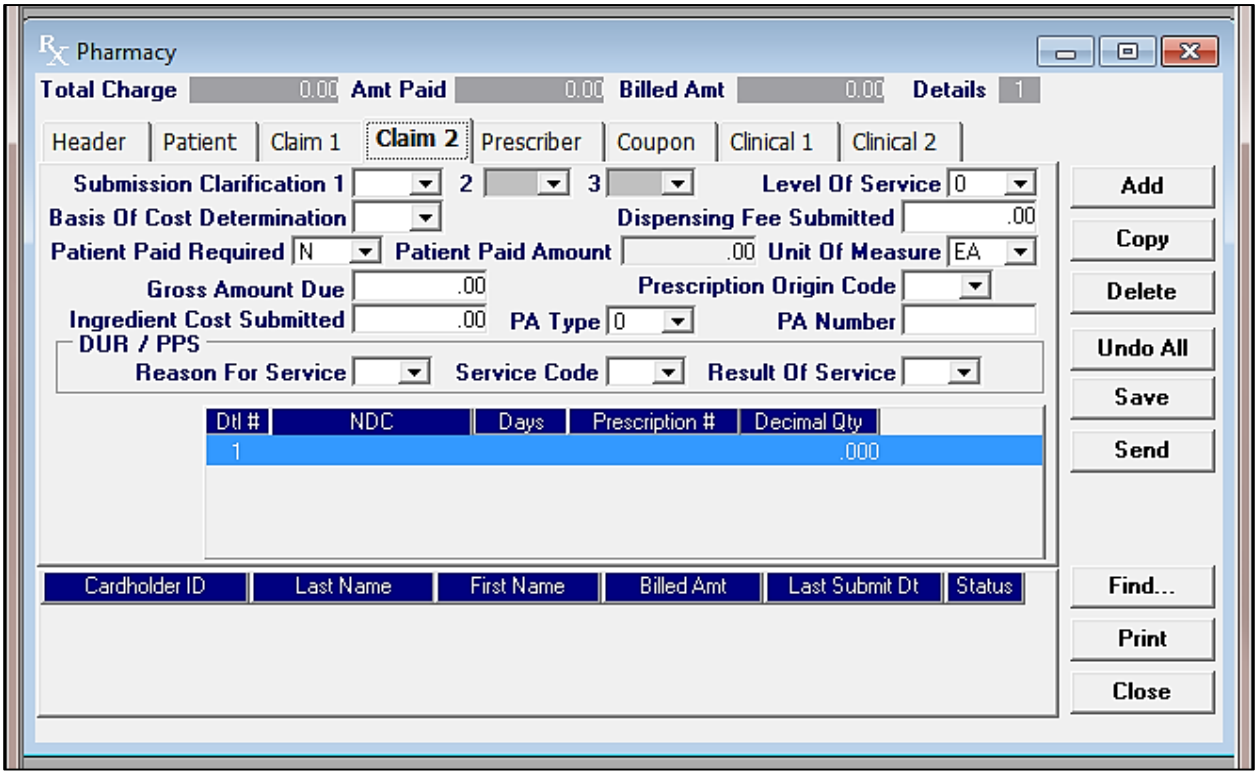
Step 3.4 Click on the new detail line to make changes to the appropriate fields.

Step 3.5 Click Delete Dtl to delete an existing detail line.

The selected detail line is deleted.

Step 3.6 Click the Claim 2 tab to access the Claim 2 screen. The software displays the Claim 2 screen.

Step 4. Complete Claim 2.



Submission Clarification	Select the submission clarification code from the drop down list, or enter an appropriate value as specified. This code indicates that the pharmacist is clarifying the submission.	
	– Default **1** – No Override **10** – Meets Plan Limitations **11** – Certification on File **12** – DME Replacement Indicator **13** – Payer-Recognized Emergency/Disaster **14** – Long Term Care Of Absence **15** – Long Term Care Replacement **16** – Long Term Care Emergency Box **17** – Long Term Care Emergency Supply **18** – Long Term Care Patient Admit **19** – Split Billing **2** – Other Override **20** – 340B **21** – LTC Dispensing: 7 Days or Less N/A	**3** – Vacation Supply **30** – LTC Dispensing: Per Shift Dispensing **31** – LTC Dispensing: Per Med Pass Dispensing **32** – LTC Dispensing: : PRN On Demand **33** – LTC Dispensing: 7 Day or Less **4** – Lost Prescription **5** –Therapy Change

	22 - LTC Dispensing: 7 Days **23** - LTC Dispensing: 4 Days **24** – LTC Dispensing: 3 Days **25** – LTC Dispensing: 2 Days **26** – LTC Dispensing: 1 Day **27** – LTC Dispensing: 4-3 Days **28** – LTC Dispensing: 2-2-3 Days **29** – LTC Dispensing: Daily and 3-Day WKND	**6** – Starter Dose **7** – Medically Necessary **8** – Process Compound For Approved Ingredients **9** – Encounters **99** - Other
Level Of Service	Select the level of service code from the drop down list, or enter an appropriate value as specified. This code identifies the type of service that was rendered.	
	0 – Not Specified **1** – Patient Consultation **2** – Home Delivery **3** – Emergency	**4** – 24 Hour Service **5** – Patient Consultation – regarding generic **6** – In-Home Service
Basis of Cost Determination	Select the Basis of Cost Determination from the drop down list, or enter an appropriate value as specified. Enter the appropriate code that indicates the method by which Ingredient Cost Submitted was calculated.	
	00 – Default **01** – AWP (Average Wholesale Price) **02** – Local Wholesaler **03** – Direct **04** – EAC (Estimated Acquisition Cost) **05** – Acquisition **06** – MAC (Maximum Allowable Cost) **07** – Usual & Customary	**08** – 340B **09** – Other **10** - ASP **11** – AMP (Average Manufacturer Price) **12** – WAC **13** – Special Patient Pricing
Dispensing Fee Submitted	Required if its value has an effect on the Gross Amount	
Patient Paid Required	Select **Yes** if co-pay was required and the recipient did not pay the co-pay.	

Patient Paid Amount	If **Yes** was selected in the Patient Paid Required field, enter **0** (zero) to indicate that the recipient did not pay the copay.	
Unit Of Measure	Select the unit of measure code from the drop down list, or enter an appropriate value as specified. Enter the appropriate standard product billing code. **EA** – Each **GM** – Grams **ML** - Milliliters	
Gross Amount Due	Predetermination Of Benefits	
Prescription Origin Code	Select the prescription origin code from the field's pull down list, or enter an appropriate value as specified. This prescription origin code identifies whether the prescription was sent in writing, electronically, by phone or by facsimile. **0** – Not Known **1** – Written **2** – Telephone **3** – Electronic **4** – Facsimile **5** - Pharmacy	
Ingredient Cost Submitted	Enter the product component cost of the dispensed prescription.	
Prior Authorization (PA) Type	Select the prior authorization code from the drop down list, or enter an appropriate value as specified. Enter the appropriate code that clarifies the prior authorization number.	
	0 – Not Specified **1** – Prior Authorization **2** – Medical Certification **3** – EPSDT **4** – Exemption from Copay **5** – Exemption from RX	**6** – Family Planning Indicator **7** – TANF **8** – Payer Defined Exemption

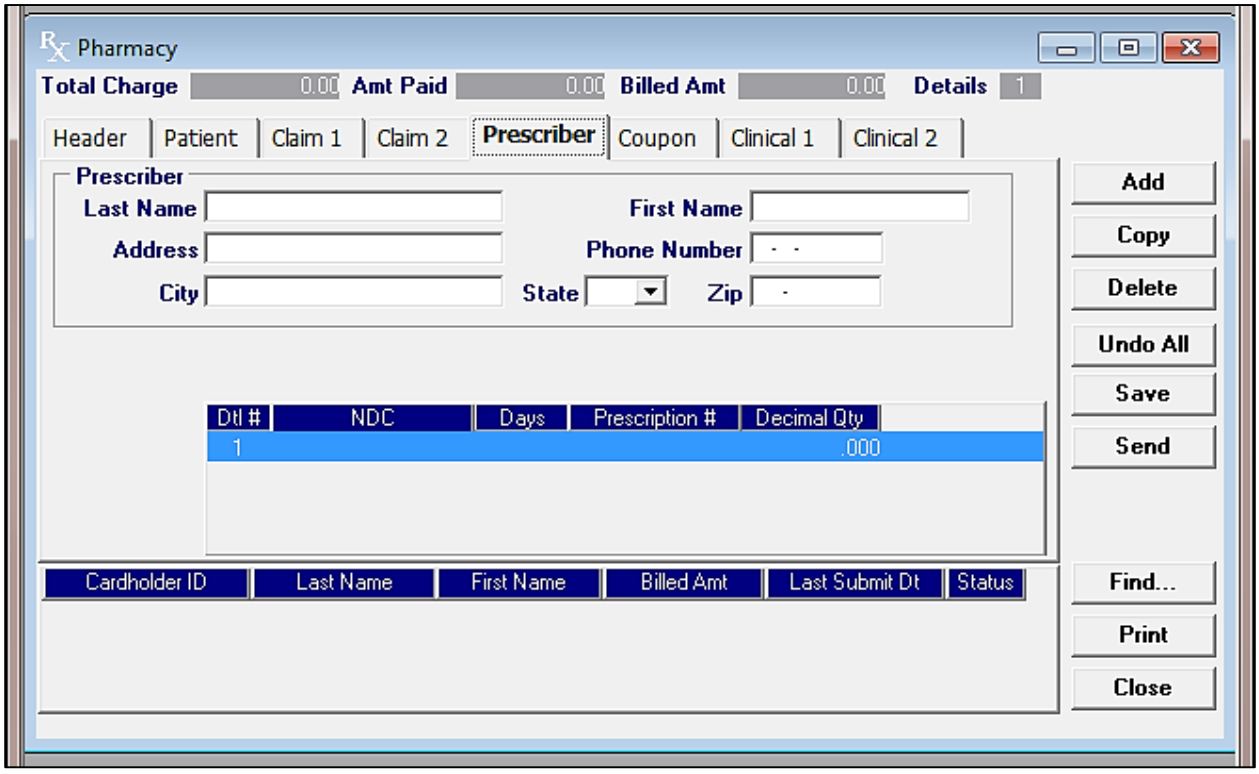
		9 – Emergency Preparedness
Prior Authorization (PA) Number	Enter the prior authorization number provided by the DHS for the prescription.	
Reason For Service (DUR/PPS)	Select the reason code from the drop down list, or enter an appropriate value as specified. This code identifies the type of conflict detected.	
	AD – Additional Drug Needed **AN** – Prescription Authentication **AR** – Adverse Drug Reaction **AT** – Additive Toxicity **CD** – Chronic Disease Management **CH** – Call Help Desk **CS** – Patient Complaint/Symptom **DA** – Drug-Allergy **DC** – Drug-Disease (Inferred) **DD** – Drug – Drug Interaction **DF** – Drug – Food Interaction **DI** – Drug Incompatibility **DL** – Drug – Lab Conflict **DM** – Apparent Drug Misuse **DS** – Tobacco Use **ED** – Patient Education/Instruction **ER** – Overuse **EX** – Excessive Quantity **HD** – High Dose **IC** – Iatrogenic Condition **ID** – Ingredient Duplication **LD** – Low Dose **LK** – Lock In Recipient **LR** – Underuse **MC** – Drug – Disease (Reported) **MN** – Insufficient Duration **MS** – Missing Information/Clarification	**PP** – Plan Protocol **PR** – Prior Adverse Reaction **PS** – Product Selection Opportunity **RE** – Suspected Environmental Risk **RF** – Health Provider Referral **SC** – Suboptimal Compliance **SD** – Suboptimal Drug/Indication **SE** – Side Effect **SF** – Suboptimal Dosage Form **SR** – Suboptimal Regimen **SX** – Drug - Gender **TD** – Therapeutic Duplication **TN** – Laboratory Test Needed **TP** – Payer/Processor Question **UD** – Duplicate Drug

	MX – Excessive Duration **NA** – Drug Not Available **NC** – Non-Covered Drug Purchase **ND** – New Disease/Diagnosis **NF** – Non-Formulary Drug **NN** – Unnecessary Drug **NP** – New Patient Processing **NR** – Lactation/Nursing Interaction **NS** – Insufficient Quantity **OH** – Alcohol Conflict **PA** – Drug - Age **PC** – Patient Question/Concern **PG** – Drug - Pregnancy **PH** – Preventive Health Care **PN** – Prescriber Consultation	
Service Code (DUR/PPS)	Select the service code from the drop down list, or enter an appropriate value as specified. This code identifies pharmacist intervention when a conflict code has been identified.	
	00 – No Intervention **AS** – Patient Assessment **CC** – Coordination Of Care **DE** – Dosing Evaluation/Determination **DP** – Dosage Evaluated **FE** – Formulary Enforcement **GP** – Generic Product Selection **M0** – Prescriber Consulted **MA** – Medication Administration **MB** – Overriding Benefit **MP** – Patient Will Be Monitored **MR** – Medication Review **P0** - Patient Consulted **PA**- Previous Patient Tolerance **PE** – Patient Education/Instruction **PH** – Patient Medication History **PM** – Patient Monitoring	**PT** – Perform Laboratory Test **RO** – Pharmacist Consulted Other Source **RT** – Recommended Laboratory Test **SC** – Self-Care Consultation **SW** – Literature Search/Review **TC** – Payer/Processor Consulted **TH** – Therapeutic Product Interchange

<table>
<tr><td rowspan="2">Result Of Service (DUR/PPS)</td><td colspan="2">Select the result code from the drop down list, or enter an appropriate value as specified. The result code identifies the action taken by a pharmacist in response to a conflict.

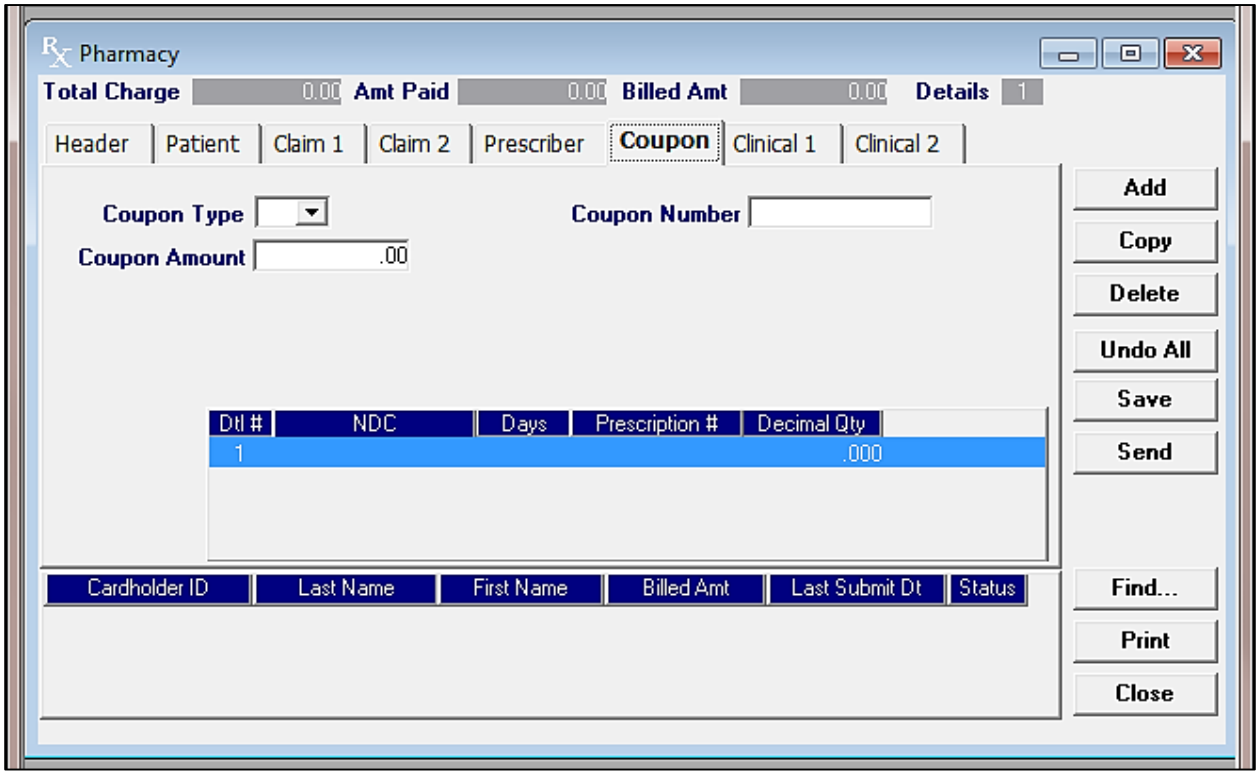
If multiple prescription detail lines were entered on the Claim 1 screen, these detail lines will also appear on the Claim 2 screen. Each detail line contains the data fields described in this step. Click on a detail line to access its data fields.</td></tr>
<tr><td>00 – Not Specified
1A – Filled As is, False Positive
1B – Filled Prescription As is
1C – Filled With Different Dose
1D – Filled With Different Directions
1E – Filled With Different Drug
1F – Filled With Different Quantity
1G – Filled With Prescriber Approval
1H – Brand-to-Generic Change
1J – Rx-to-OTC Change
1K – Filled with Different Dosage Form
2A – Prescription Not Filled
2B – Not Filled, Directions Clarified</td><td>3A – Recommendation Accepted
3B – Recommendation Not Accepted
3C – Discontinued Drug
3D – Regimen Changed
3E – Therapy Changed
3F Cost Increased Acknowledged
3G – Drug Therapy Unchanged
3H – Follow-Up/Report
3J – Patient Referral
3K – Instructions Understood
3M – Compliance Aid Provided
3N – Medication Administered
4A – Prescribed with ACK</td></tr>
</table>

Step 5. Complete Prescriber



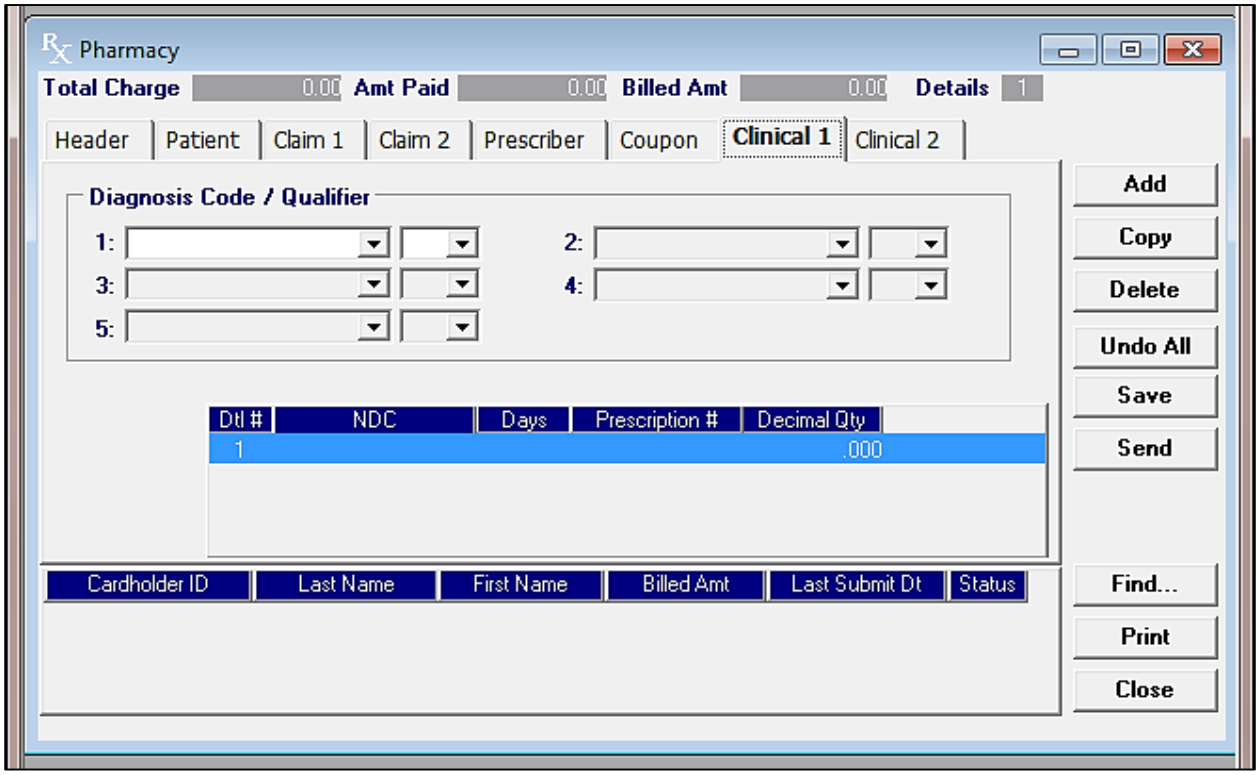
Last Name (Prescriber)	Enter the Last name of the Prescriber.
First Name (Prescriber)	Enter the First name of the Prescriber.
Address (Prescriber)	Enter the Address of the Prescriber.
Phone Number (Prescriber)	Enter the phone number starting with the area code-do not put in the dashes.
City (Prescriber)	Enter the City for the Prescriber
State (Prescriber)	Enter the State using the drop down list.
Zip (Prescriber)	Enter the 9-digit zip code corresponding to the city and state listed in the City and State fields. This field holds a maximum of 9-numeric characters.

Step 6. Complete Coupon



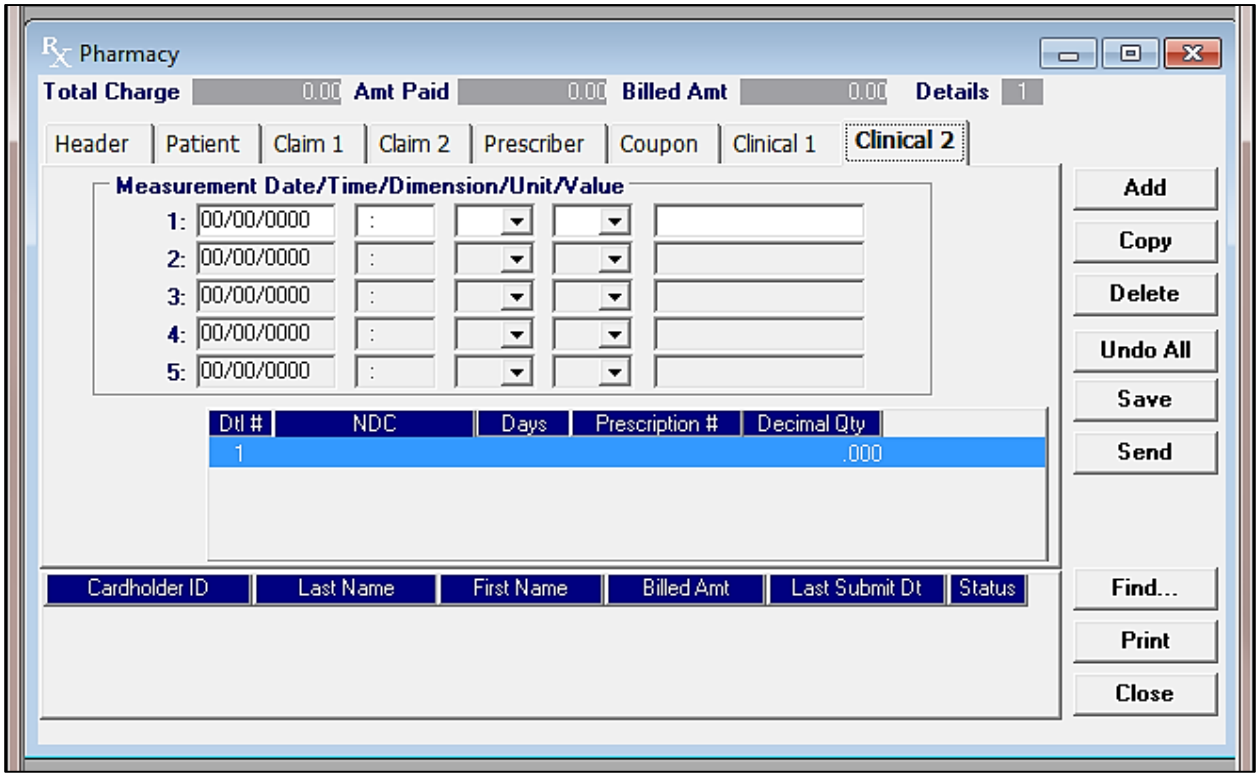
Coupon Type	Select the Coupon Type from the drop down list or enter an appropriate value as specified. **01** – Price Discount **02** – Free Product**99** – Other
Coupon Number	Enter the Coupon Number
Coupon Amount	Enter the amount for the Coupon amount

Step 7. Complete Clinical 1



Diagnosis Code/Qualifier	Select the code from the drop-down list that identifies the diagnosis code or enter the ICD-9-CM/ICD-10-CM/PCS diagnosis code that relates to a recipient's diagnosis as specified. Qualifier: **00** – Not Specified **01** – ICD9 **02** – ICD10 **03** – National Criteria Care Institute **04** – SNOMED **05** – Common Dental Terminology **06** – Medi-Span Product Line **07** – DSM IV **08** – FDBDX **09** – FDB DXID **99** - Other

Step 8. Complete Clinical 2

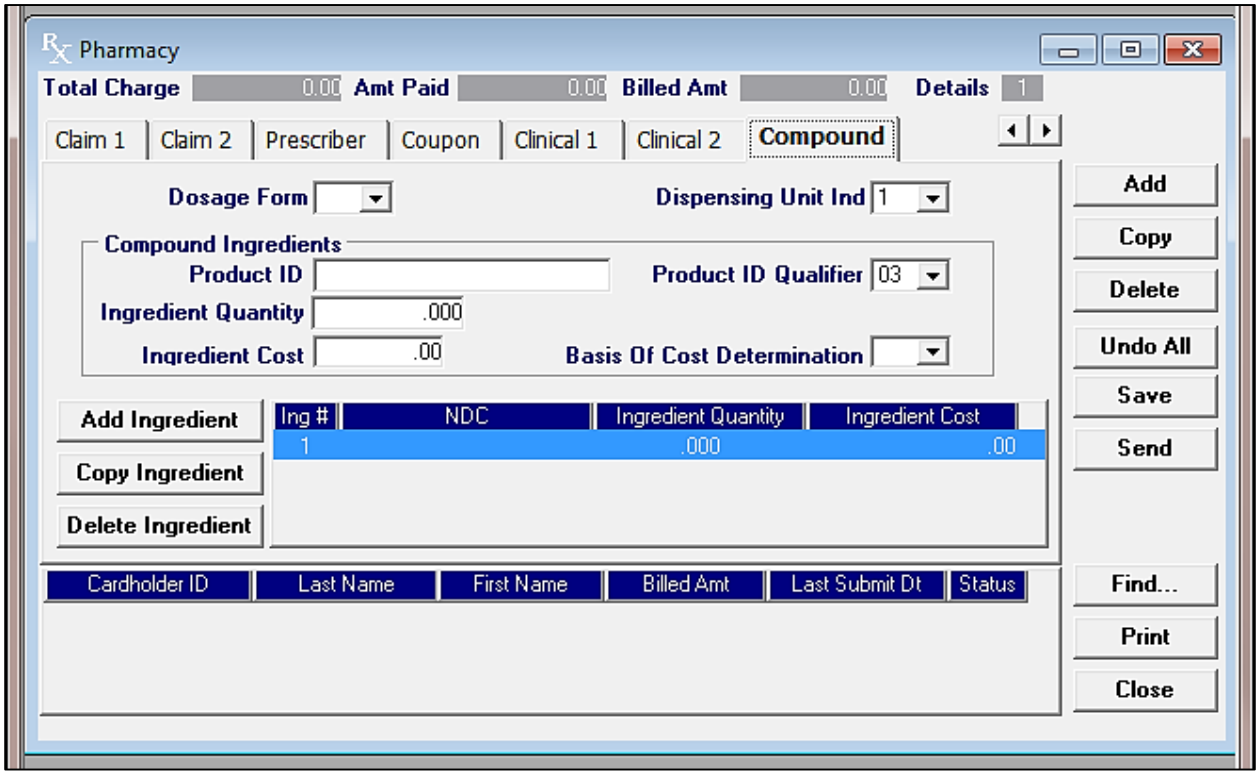


Measurement Date	Enter the 2-digit month, 2-digit day, and 4-digit year. For example, enter 01012015 if the date was January 1, 2015.
Time	Required if Time is known or has impact on measurement.

Dimension	Required if Measurement Unit and Measurement Value are used. Enter using the drop down list or enter an appropriate value as specified. - Not Specified **01** – Blood Pressure (BP) **02** – Blood Glucose **03** – Temperature **04** – Serum Creatinine (SCR) **05** – Glycosylated Hemoglobin (HBA1C) **06** – Sodium (NA+) **07** – Potassium (K+) **08** – Calcium (CA++ **09** – Serum Glutamic–Oxaloacetic Tran **10** - Serum Glutamic–Pyruvic Trans **11** – Alkaline Phosphatase **12** - Theophylline **13** – Digoxin **14** – Weight **15** – Body Surface Area (BSA) **16** – Height **17** – Creatinine Clearance (CRCL) **18** – Cholesterol **19** – Low Density Lipoprotein (LDL) **20** - High Density Lipoprotein (HDL) **21** – Triglycerides (TG) **22** – Bone Mineral Density (BMD T-Score) **23** – Prothrombin Time (PT) **24** - Hemoglobin (HB HGB) **25** – Hematocrit (HCT) **26** – White Blood Cell Count (WBC) **27** – Red Blood Cell Count (RBC) **28** – Heart Rate **29** – Absolute Neutrophil Count (ANC) **30** – Activated Partial Thromboplastin **31** – CD4 Count **32** – Partial Thromboplastin Time (PTT) **33** – T-Cell Count

	34 – INR-International Normalized Ratio **99** – Other
Unit	Required if Measurement Dimension and Measurement Value are used. Enter a value from the drop down list or enter an appropriate value as specified: Not Specified **01** – Inches **02** – Centimeters **03** – pounds **04** – Kilograms **05** – Celsius **06** – Fahrenheit **07** – Meters Squared **08** – Milligrams **09** – Units per Milliliter **10** – Millimeters of Mercury **11** - Centimeters **12** – Milliliters Per Minute **13** – Percent **14** – Milliquivalents Per Milliliter **15** – International Units Per Liter **16** – Micrograms Per Milliliter **17** – Nanograms Per Milliliter **18** – Milligrams Per Milliliter **19** – Ratio **20** – SI Units **21** – Millimoles/Liter **22** – Seconds **23** – Grams **24** – Cells Per Cubic Millimeter **25** – 1,000,000 Cells/Cubic Millimeter **26** – Standard Deviation **27** – Beats Per Minute
Value	Required if Measurement Dimension and Measurement Unit are used.

Step 9. Complete Compound



Step 9.1 Select **02** in the Compound Ind field on the Claim 1 screen to display the Compound screen.

Step 9.2 Click the Compound tab to access the Compound screen by.

Dosage Form	Select the form in which the dosage of the prescription is dispensed from the drop down list or enter an appropriate value as specified. Examples: tablet, powder, capsule, liquid, etc. Not Specified **01** – Capsule **02** – Ointment **03** – Cream **04** – Suppository **05** – Powder **06** – Emulsion **07** – Liquid **10** – Tablet **11** – Solution **12** – Suspension

	13 – Lotion **14** – Shampoo **15** – Elixir **16** – Syrup **17** – Lozenge **18** – Enema
Dispensing Unit Ind	Select the unit of dosage in which the prescription is dispensed from the drop down list or enter an appropriate value as specified. Examples: each, gram, milliliters, etc. **1** – Each **2** – Grams **3** - Milliliters
Product ID (Compound Ingredients)	Select the product ID number for the ingredient from the drop down list, or enter an appropriate value as specified. This field is required if the compound indicator field contains the value **2**, which indicates that the claim is for a compound.
Product ID Qualifier (Compound Ingredients)	Qualifier code for the product ID number. This field is required if the compound indicator field contains the value 2, which indicates that the claim is for a compound. Select the appropriate value from the drop down list or enter an appropriate value as specified. **01** – UPC **02** – HRI **03** – National Drug Code (NDC) **04** – HIBCC **11** - NAPPI **12** – GTIN **15** – GCN **28** – FDB Med Name ID **29** – FDB Routed Med ID **30** – FDB Routed Dosage Form Med ID **31** – FDB MEDID **32** – GSN **33** – HICL **99** - Other

Ingredient Quantity (Compound Ingredients)	Enter the quantity of the ingredient used in the prescription, expressed in numeric metric decimal units. This must be a whole number. This field is required if the compound indicator field contains the value **2**, which indicates that the claim is for a compound.
Ingredient Cost (Compound Ingredients)	Enter the ingredient cost for the quantity entered in the Ingredient Quantity field, including a decimal point. This field is required if the compound indicator field contains the value **2**, which indicates that the claim is for a compound.
Basis of Cost Determination (Compound Ingredients)	Select the Basis of Cost Determination from the drop down list ***or*** Enter an appropriate value as specified. Enter the appropriate code that indicates the method by which Ingredient Cost Submitted was calculated. Each NCPDP pharmacy claim can have a maximum of twenty-five ingredient lines. Each ingredient line contains the data fields described in this step. **00** – Default **01** – AWP(Average Wholesale Price) **02** – Local Wholesaler **03** – Direct **04** – EAC (Estimated Acquisition Cost) **05** – Acquisition **06** – MAC (Maximum Allowable Cost) **07** – Usual & Customary **08** –3408/Disproportionate Share **09** – Other **10** – ASP (Average Sales Price) **11** – AMP (Average Manufacturer Price) **12** – WAC (Wholesale Acquisition Cost) **13** – Special Patient Pricing

Step 9.3 Click

to add another ingredient line.

A new blank ingredient line is added to the screen.

Step 9.4 Click on the new ingredient line, and then enter the ingredient data in the appropriate data fields.

Step 9.5 Click on the existing ingredient line information you want to copy to a new ingredient line.

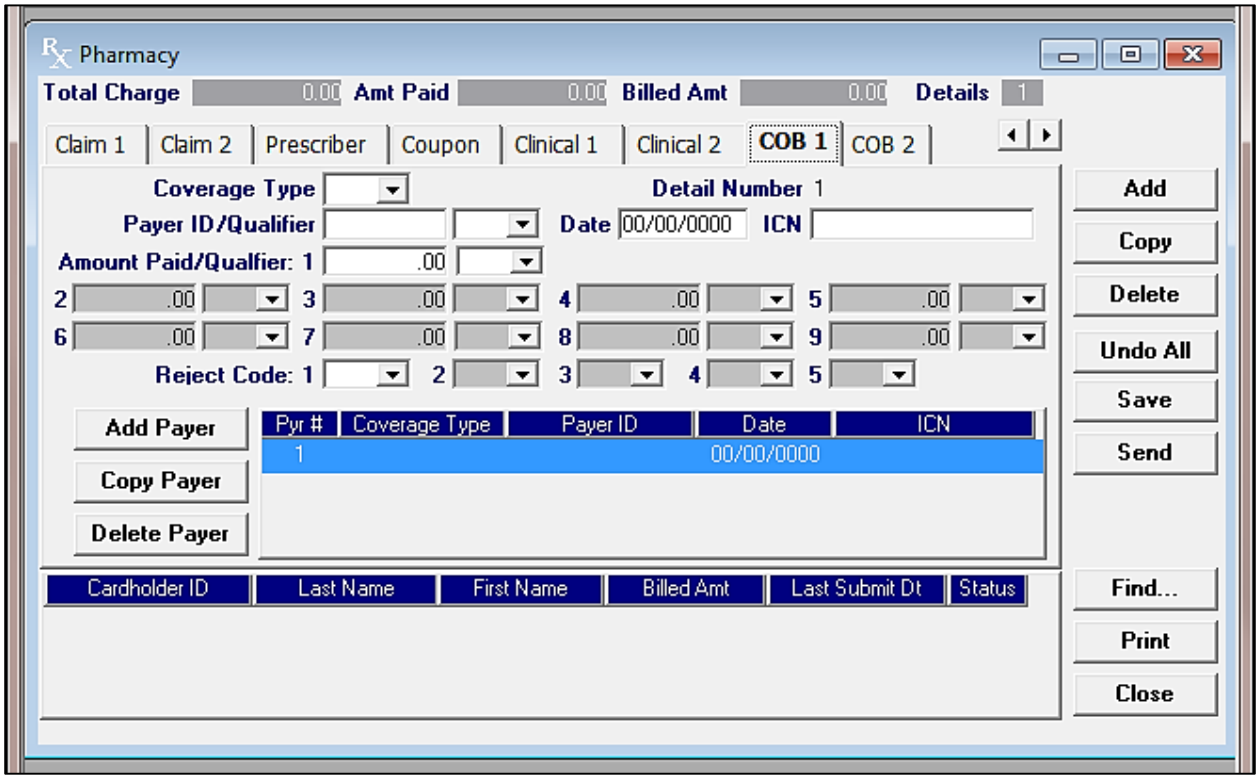
Step 9.6 Click **Copy Ingredient**. The new ingredient information is copied to the new line.

The new ingredient line has the same data as the existing ingredient line you previously selected. You can edit the data in the new ingredient line.

Step 9.7 Click on the new ingredient line to make changes to the appropriate fields.

Step 9.8 Click on the ingredient line you want to delete, and then click **Delete Ingredient** to delete an existing ingredient line.

Step 10. Complete COB 1.



Step 10.1 Select 02 from the Other Coverage Code field on the Claim 1 screen to display the COB 1 screen.

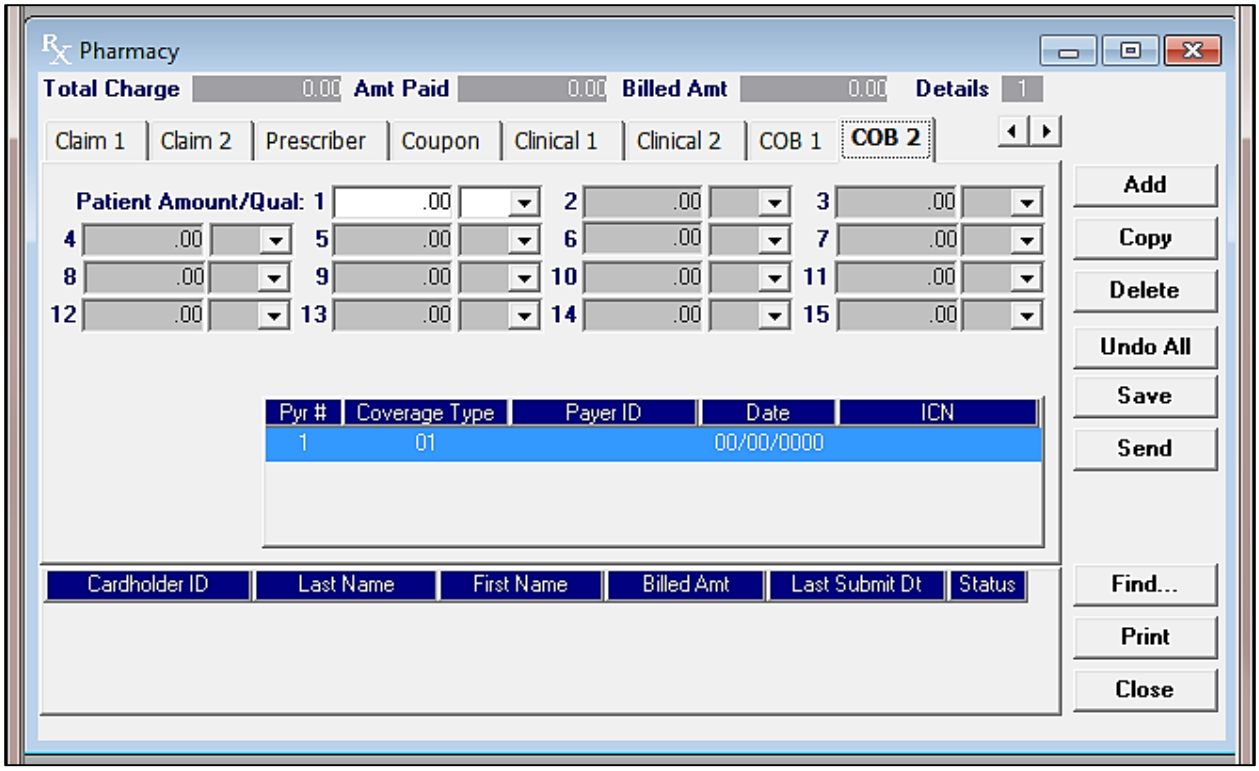
Step 10.2 Click the COB 1 tab to access the COB 1 screen.

The COB 1 screen is displayed.

Coverage Type	Select the coverage code from the drop down list or enter an appropriate value as specified. Not Specified **01** – Primary - First **02** – Secondary - Second **03** – Tertiary – Third **04** – Quaternary – Fourth **05** – Quinary – Fifth **06** – Senary - Sixth **07** – Septenary - Seventh **08** – Octonary - Eighth **09** – Nonary - Ninth
Payer ID/Qualifier	Select the qualifier from the drop down list or enter an appropriate value as specified. **01** –National Payer ID **02** – Health Industry Number **03** – Bank Information Number **04** – National Association of Insurance **05** – Medicare Carrier Number **99** – Other
Date	Enter the 2-digit month, 2-digit day, and 4-digit year. For example, enter 01012015 if the date was January 1, 2015.
ICN	Internal Control Number – unique claim number that distinguishes claims within PROMISe™ and appears on a Remittance Advice statement.
Paid Amount/Qualifier	Enter the amount received from other payers associated with the Qualifier selected. Use a decimal point. For example, enter 100.23 if the adjustment amount was $100.23. Enter the paid amount. Select the qualifier from the drop down list or enter an appropriate value as specified. **01** –Delivery **02** – Shipping **03** – Postage **04** – Administrative **05** – Incentive **06** – Cognitive Service

	07 – Drug Benefit **09** – Compound Preparation Cost **10** – Sales Tax
Reject Code	Enter a value from the drop down list or enter an appropriate value as specified.

Step 11. Complete COB 2



Enter the Patient Amount and Qualifier when the recipient owes for any of the reasons listed.

Patient Amount/Qualifier	Enter a value from the drop down list or enter an appropriate value as specified. Not Specified **01** – Amount Applied Periodic Deductible **02 –** Amount Attributed Product Selection **03 –** Amount Attributed to Sales Tax **04** – Amount Exceeding Periodic Benefit **05** – Amount of Copay **06** – Patient Pay Amount **07** – Amount of Coinsurance **08** – Non-Preferred Formulary Selection **09** – Amount Attributed to Health Plan **10** – Amount Attributed Provider Network **11** – Brand Non-Preferred Formulary **12** – Amount Attributed to Coverage Gap **13** – Amount Attributed to Processor Fee

Step 12. Click Save to save the NCPDP Pharmacy claim.

Step 13. Click Close to exit the NCPDP Pharmacy Form.

9.10 Complete an NCPDP Pharmacy Eligibility Form

The NCPDP Pharmacy Eligibility Form is used by Pharmacies to request verification of a recipient's eligibility status. The NCPDP Pharmacy Eligibility Form consists of only the Header screen. The Header screen contains the provider and recipient information.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

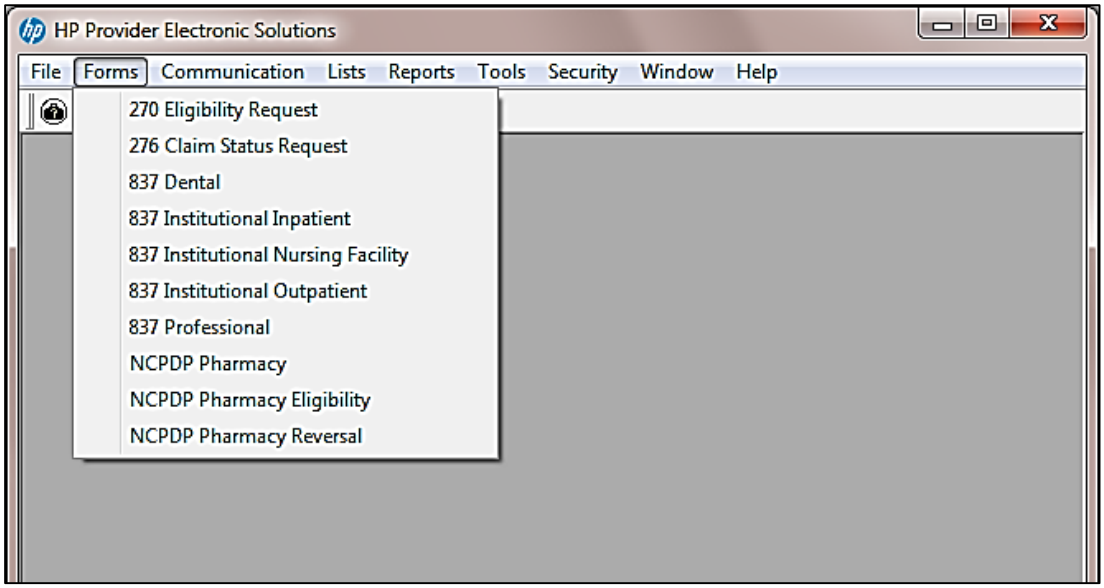
To create a pharmacy eligibility inquiry, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, access the NCPDP Pharmacy Eligibility Form one of these two ways:

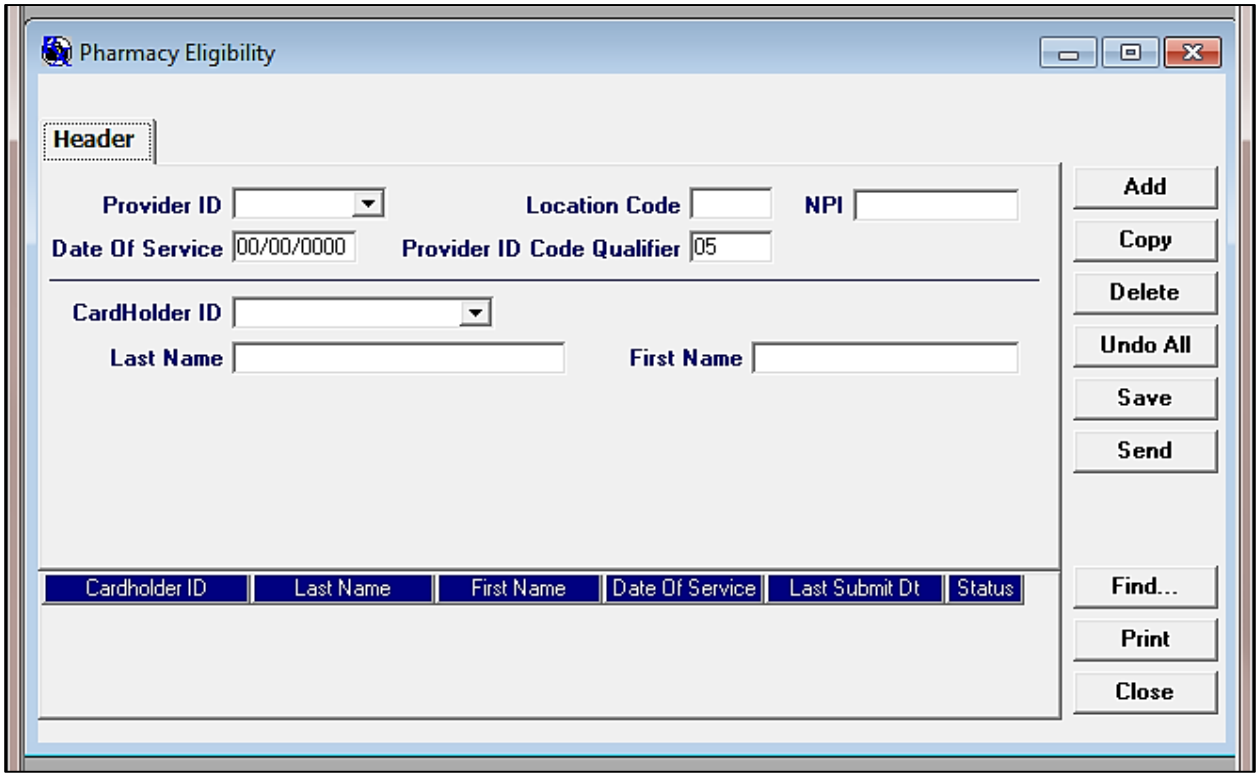
Click (Rx Eligibility Shortcut icon) on the Toolbar

or

Select the **NCPDP Pharmacy Eligibility** option from the **Forms** drop down menu or enter an appropriate value as specified.



Step 2. Complete Pharmacy Eligibility.



When you choose a selection from a drop down list, or enter an appropriate value as specified, many of the fields are populated.

A drop down list is also known as a reference list.

For additional information on reference lists, refer to the List options in Section 6.

Provider ID	Select the 9-digit MPI for the payee from the drop down list, or double-click on the data entry portion of the field to add a reference list selection.
Location Code	4-digit location code associated with the 9-digit MPI selected. This field is automatically populated after you select a Provider ID. Pharmacists who qualify as a QSB should add a **Q** as the fifth character in the Location Code.
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Date Of Service	Enter the 2-digit month, 2-digit day, and 4-digit year on which the service was provided. For example, enter 01012015 if the date was January 1, 2015.
Provider ID Qualifier	Qualifier code for the Provider ID Number. The qualifier code must always be **05** for NCPDP providers.
Cardholder ID	Select the cardholder ID number from the drop down list or double-click on the data entry portion of the field to add a reference list selection. Cardholder ID numbers are issued to recipients who are authorized to receive Pennsylvania Medicaid services. The cardholder ID consists of the 10-digit Recipient ID number and 2-digit Card Issue Number as printed on the recipient's card.
Last Name	Recipient's last name. This filed is automatically populated after you select a Cardholder ID from the Cardholder ID field.
First Name	Recipient's first name. This filed is automatically populated after you select a Cardholder ID from the Cardholder ID field.

Step 3. Click

to save the pharmacy eligibility inquiry.

Step 4. Click

to exit the NCPDP Pharmacy Eligibility form.

9.11 Complete an NCPDP Pharmacy Reversal Form

The NCPDP Pharmacy Reversal form is used by Pharmacies to create reversal requests for pharmacy claims. This form consists of the Header Reversal screen and the Claim Reversal screen. The Header Reversal screen contains the provider information and the Date of Service. The Claim Reversal screen contains the prescription information.

For additional information on a particular field, highlight the field with your mouse and press **F1.**

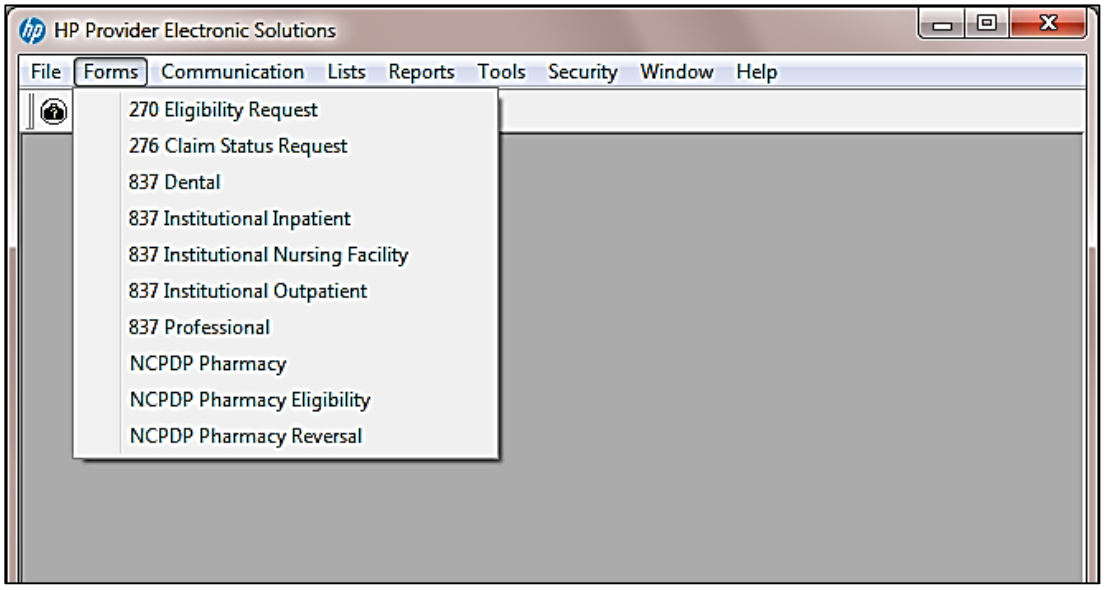
To create a pharmacy reversal request, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, access the NCPDP Pharmacy Reversal Form in one of two ways:

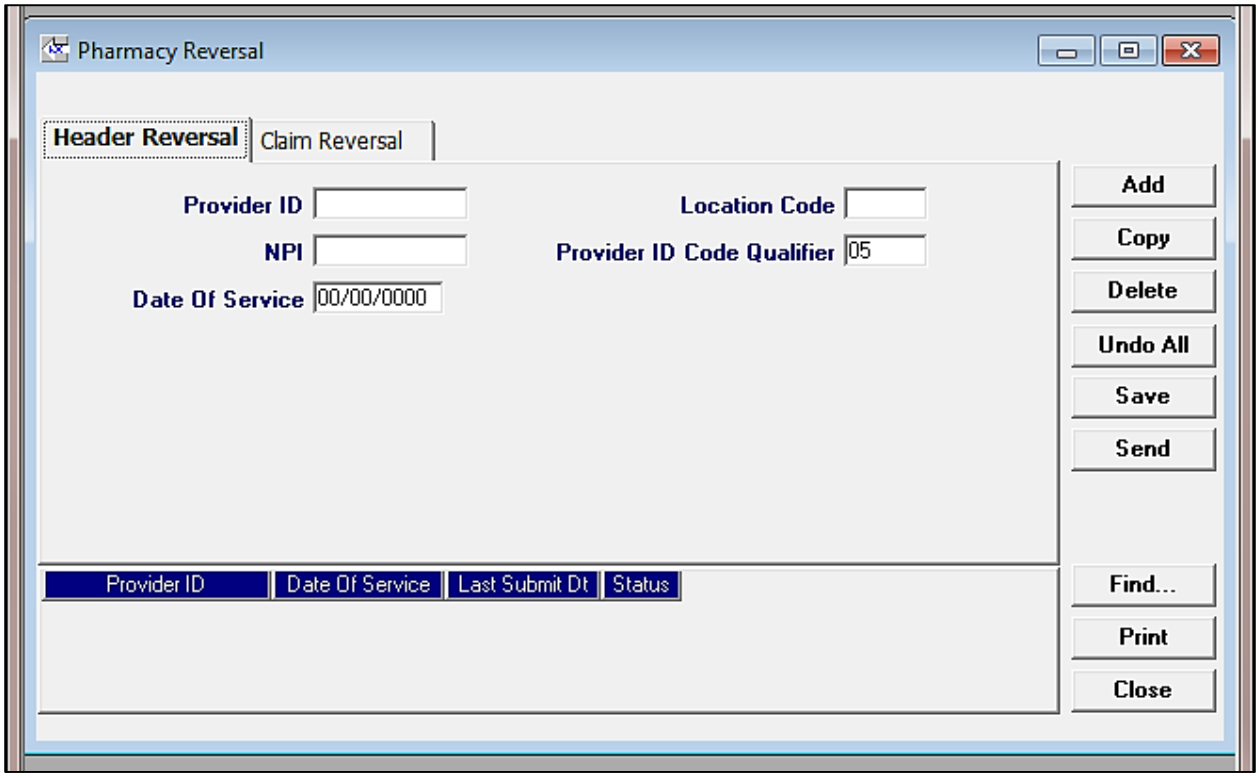
Click (NCPDP Pharmacy Reversal Shortcut icon) on the Toolbar

or

Select the **NCPDP Pharmacy Reversal** option from the **Forms** drop down menu.



The NCPDP Pharmacy Reversal Form appears, with the Header Reversal screen displayed.

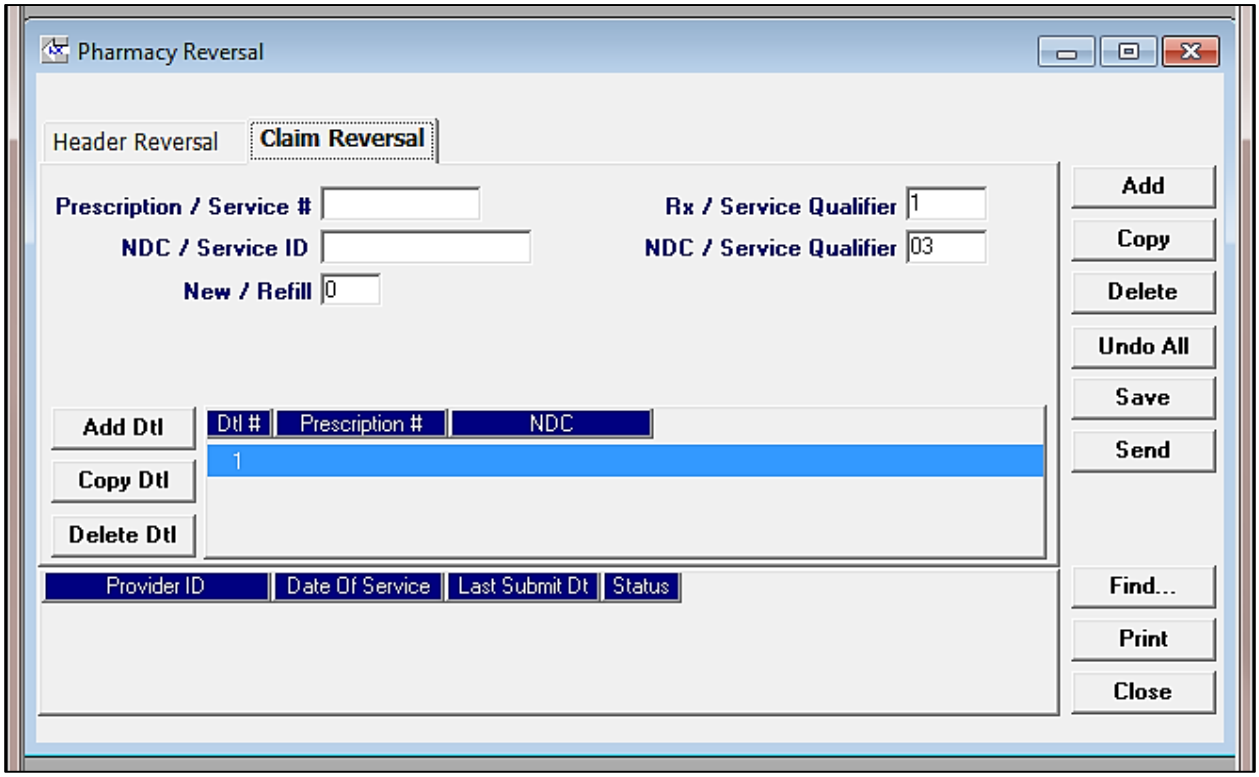


Step 2. Complete Header Reversal.

Provider ID	Select the 9-digit MPI for the payee from the drop down list, or double-click on the data entry portion of the field to add a reference list selection. This is the number under which the claim was paid.
Location Code	The 4-digit location code associated with the 9-digit MPI selected. This field is automatically populated after you select a Provider ID. Pharmacists who qualify as a QSB should add a **Q** as the fifth character in the location code.
NPI	Enter the NPI (National Provider Identifier) - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
Provider ID Qualifier	Qualifier code for the provider ID number. This code must always be **05** for NCPDP providers.
Date Of Service	Enter the 2-digit month, 2-digit day, and 4-digit year on which the service was provided. For example, enter 01012015 if the date was January 1, 2015.

Step 3. Click the Claim Reversal tab to access the Claim Reversal screen.

The Claim Reversal screen is displayed.



Prescription / Service #	Enter the ID number of the prescription that was filled. If the prescription number is less than 12 numeric characters, add zeroes to the beginning of the prescription number to make it equal to 12 characters. (ex. 000000001234)
Rx / Service Qualifier	Select the qualifier code from the drop down list, or enter an appropriate value as specified. The qualifier code must always be **1**.
NDC / Service ID	Select the eleven-digit NDC for drug dispensed.
NDC / Service Qualifier	Qualifier code for the NDC code. The qualifier code must always be **03** for NCPDP forms.
New/Refill	Enter a number to indicate whether the prescription is the original prescription or a refill. Enter **0** to indicate that this is the first time the prescription is filled.

Step 4. Click Save to save the pharmacy reversal request.

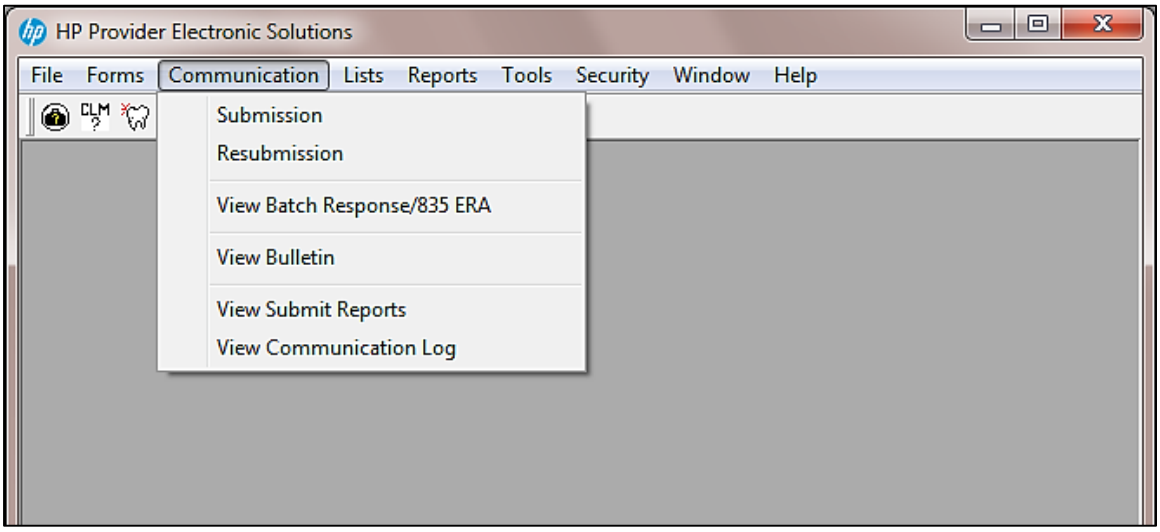
Step 5. Click Close to exit the NCPDP Pharmacy Reversal Form.

10 Communication Tools and Functions

The Provider Electronic Solutions software provides several functions related to communicating with DHS. These functions include the following:

- Submit forms through Web Internet, (Dial-up or diskette submission is no longer available).
- Resubmit batch forms through Web Internet submission.
- View and print transaction responses.
- View and print communication logs.

Access these functions from the **Communication** menu on the main screen of the Provider Electronic Solutions software.



10.1 Batch Submission

Use the Batch Submission function to transmit forms and inquiries for processing in the PROMIS*e*™ system. This function also lets you receive responses from the PROMIS*e*™ system.

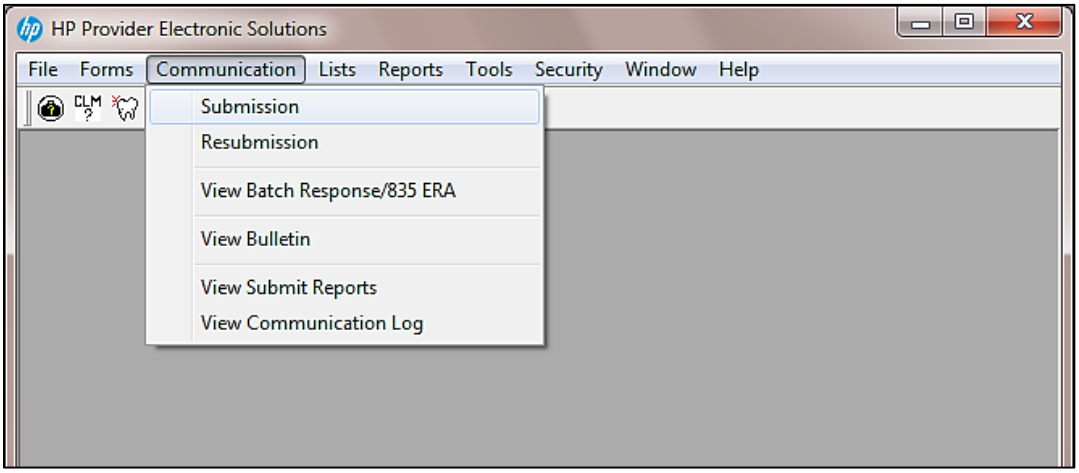
The Submission option lets you send and receive multiple form types at the same time. Each form type is equal to a batch.

For example, if you are sending a 270 Eligibility Request file and an 837 Professional file, you are sending two batches.

Keep in mind that although you may be sending several forms in the same batch file, those forms may be returned with other batches of the same form type. There is no guarantee that all batches will be processed together.

To submit and receive files perform the following:

Step 1. Select the **Submission** option from the **Communication** menu.



Step 2. Select the appropriate submission method from the **Method** drop down list. (To submit via Web Internet. (Modem, or diskette are no longer available) The default is Web Server.

The default is Web Server (if it is not selected - Select the **Web Server** option to submit by Web Internet.

The **BBS Batch** option to submit by modem is no longer available.

Step 3. **Note:** Diskette and BBS Batch are no longer available. Select the type of files you want to send to HP Enterprise Services from the **Files To Send** list.

You can select a file type by clicking on it.

Multiple files can be sent at the same time.

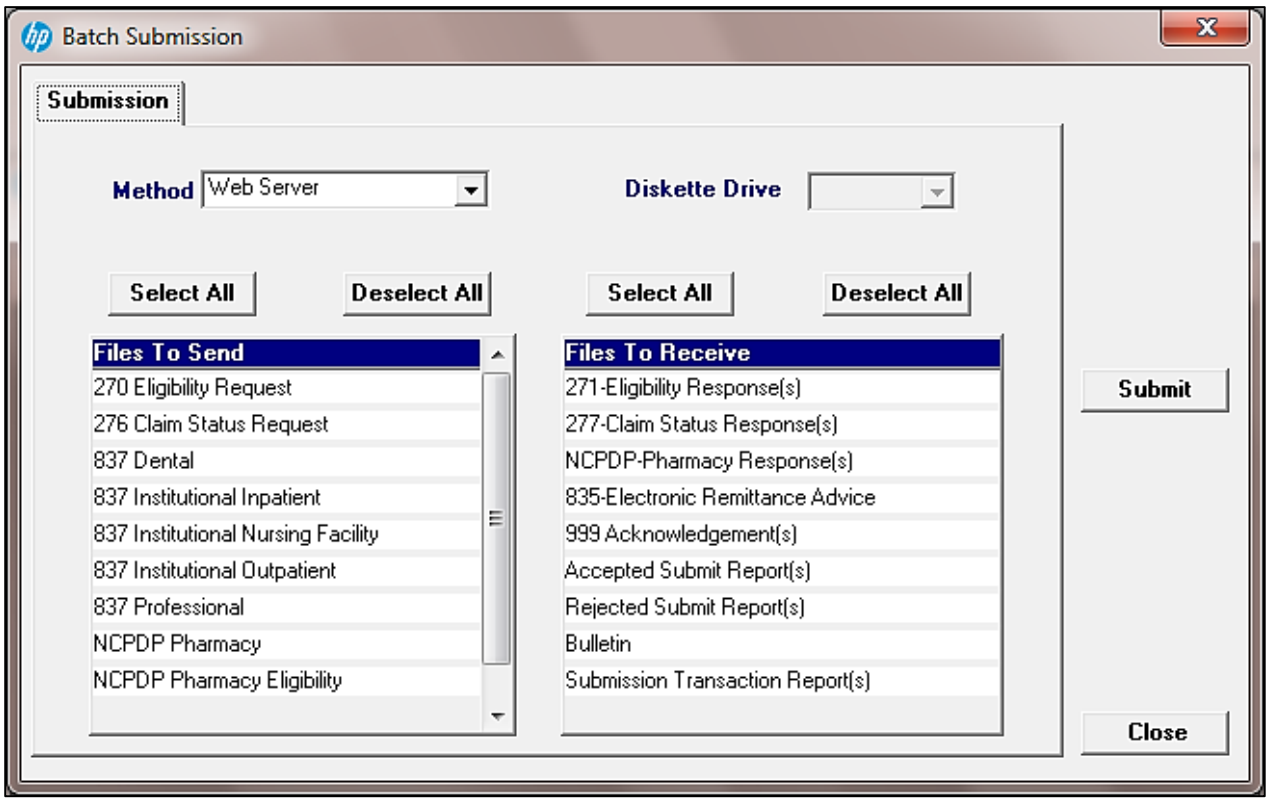
Step 4. Click **Select All** to select all the files listed.

If you try to send a file type that does not currently have any files attached to it, you will receive the error message, "No records in ready status."

Step 5. When submitting by Web Internet you can send and receive files simultaneously. To receive files, select the type of files you want to receive back from DHS, from the **Files To Receive** list. You can select a file type by on clicking it. **Note: This is required in order to verify that all of the claims submitted were accepted.**

Step 6. Click **Select All** to select all the files listed.

Step 7. Click Submit to send and receive the files you have selected in Steps 3 and 4.



Step 8. Click Close to exit the Batch Submission screen.

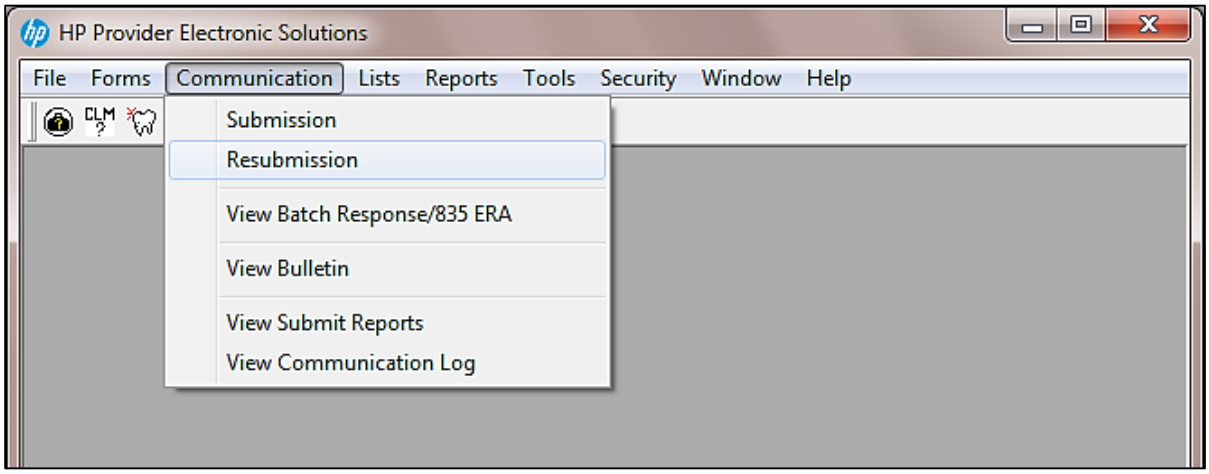
10.2 Batch Resubmission

The Batch Resubmission function is used to resubmit previously transmitted forms to DHS to identify the forms that were sent with each batch, or to copy a form for revision purposes.

Please note that resubmitted claims are sent with exactly the same information as they contained when they were originally transmitted**. If you have changed information and need to transmit the new information, you will perform a submission, not a resubmission.**

To resubmit previously transmitted forms to DHS, perform the following steps:

Step 1. Select the **Resubmission** option from the **Communication** drop down menu, located on the main screen of the Provider Electronic Solutions software:



The Resubmission screen appears, with a list of previously submitted batches at the top of the screen.

Step 2. Select the batch file by clicking on any of the batches in the Batch Resubmission box. Claims sent in that batch file appear at the bottom of the screen. In the example below, three claims were sent with the batch file that was selected.

Step 3. Click the batch file you would like to resubmit to resubmit a batch.

Step 4. Click **Select All** to select all the batch files (forms) for resubmission.

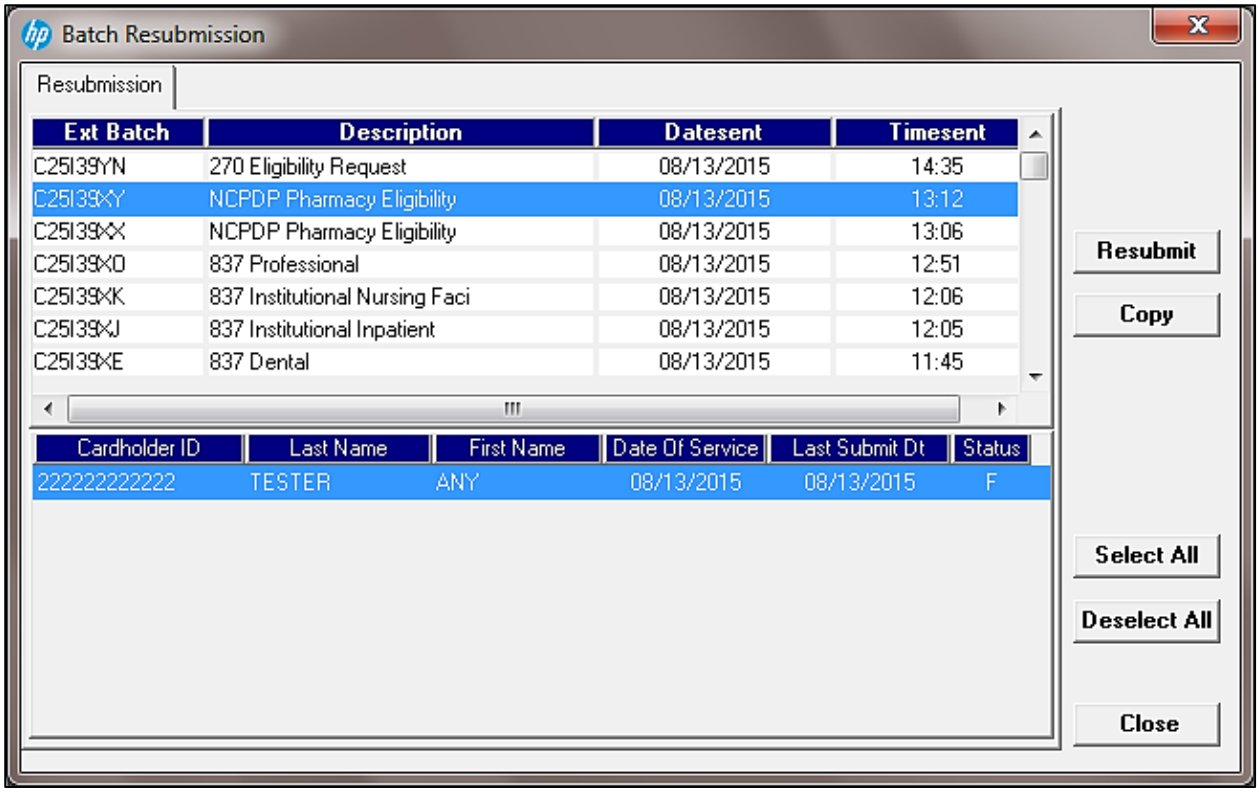
Step 5. Click **Deselect All** if you want to deselect all the files for resubmission,

Step 6. Select the batch the claim was sent with to copy a file for revision.

Step 7. Select the claim and then click **Copy** to copy a claim.

The copied claim is placed in the appropriate **Form** option in "Ready" (R) status, which can be accessed from the Forms Menu or Form short-cut icon from the main screen of the Provider Electronic Solutions software.

For example, if you copied an 837 Professional Form, you would access the 837 Professional Form screen through the Forms Menu, or by clicking on the appropriate short cut icon. After you have accessed the 837 Professional Form screen, you will see that the copied claim appears in the list at the bottom of the screen.



Step 8. Click **Resubmit** to complete the resubmission procedure.

Step 9. Click **Close** to exit the Resubmission screen.

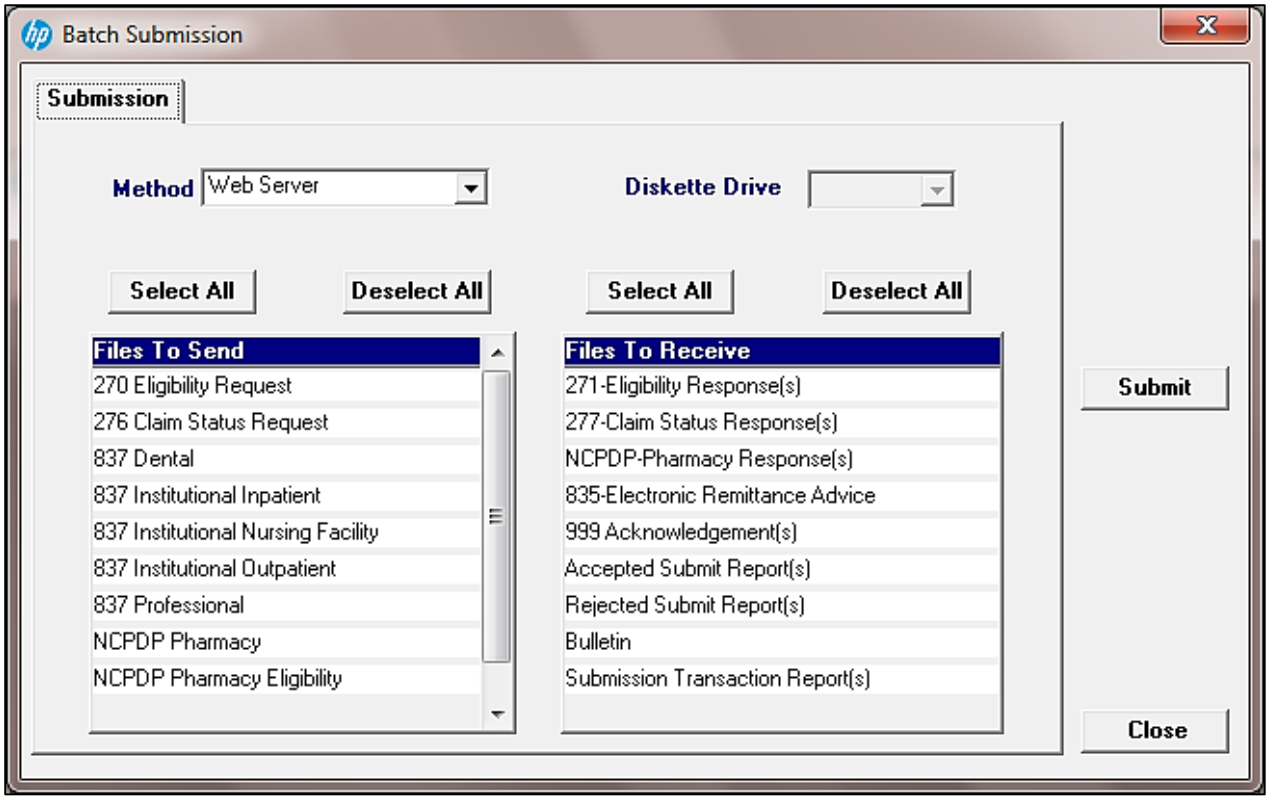
10.3 Batch Responses

Use the Batch Submission function to download Batch Responses. The responses are listed under the **Files to Receive**.

Note: This is required in order to verify that all of the claims submitted were accepted.

The Submission option lets you receive multiple responses at the same time.

For example, if you are receiving a Submission Transaction Report (TXN) and an 835 Electronic Remittance Advice, you are receiving two files.



To receive responses, perform the following steps:

Step 1. Select the **Submission** option from the **Communication** option in the Main Menu of the Provider Electronic Solutions software.

Step 2. Select appropriate submission method from the **Method** drop down list (**Default is the Web Server**-Only option available).

Note: BBS Batch and Diskette are no longer available.

Select the type of responses you want to receive under the **Files to Receive** list.

Select the response type by clicking on it.

Multiple responses can be requested at the same time.

Note: Always select the Submission Transaction Report(s), Accepted Submit Report(s) and the Rejected Submit Report(s) for the files to receive. You should also select 999 Acknowledgement(s) for any files that may have rejected for HIPAA errors.

Step 3. **Step 4**. Click Select All to select all the batch responses for receipt.

10.4 View and Print Batch Response/835 Electronic Remittance Advice

The View Batch Response/835 ERA option allow you to view and print a 271 Eligibility Responses or an 835 Electronic Remittance Advices (ERA).

Note: CARC - Claim Adjustment Reason Codes

RARC – Remittance Advice Remark Codes

Additional information is located at the following links.

******* For complete CARC/RARC Descriptions, please visit the following web site: *******

Washington Publishing Company **http://www.wpc-edi.com**

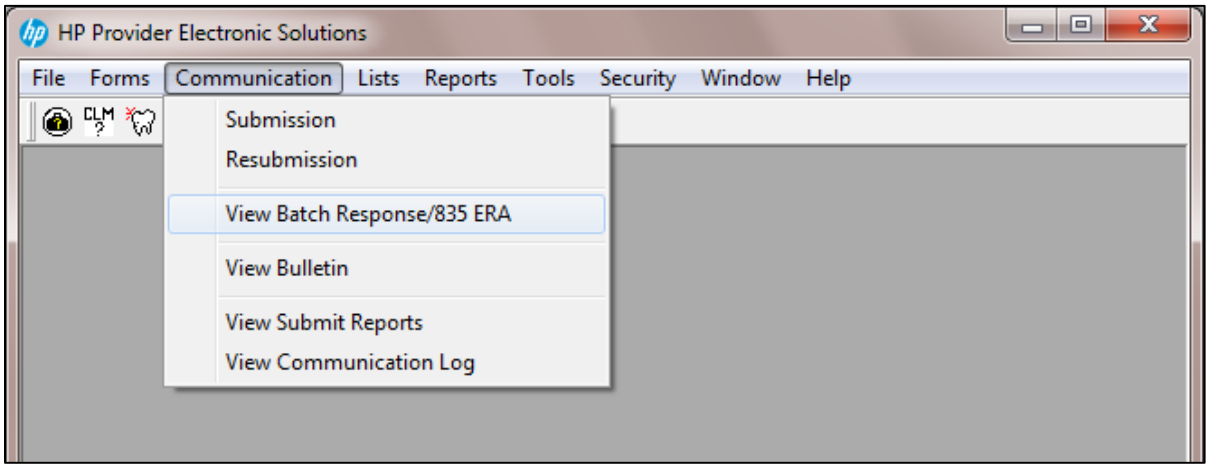
CAQH CORE website **http://www.caqh.org**

The View Batch Response/835 ERA option lets you view and print a Batch of 271 Eligibility Responses or an 835 ERA.

To view a 271 Eligibility Response or the 835 ERA, perform the following steps:

Step 1. Download the reports using the instructions provided in section 10.3 – Batch Responses.

Step 2. Select the **View Batch Response/835 ERA** option from the **Communication** menu located on the Main Menu of the Provider Electronic Solutions software.

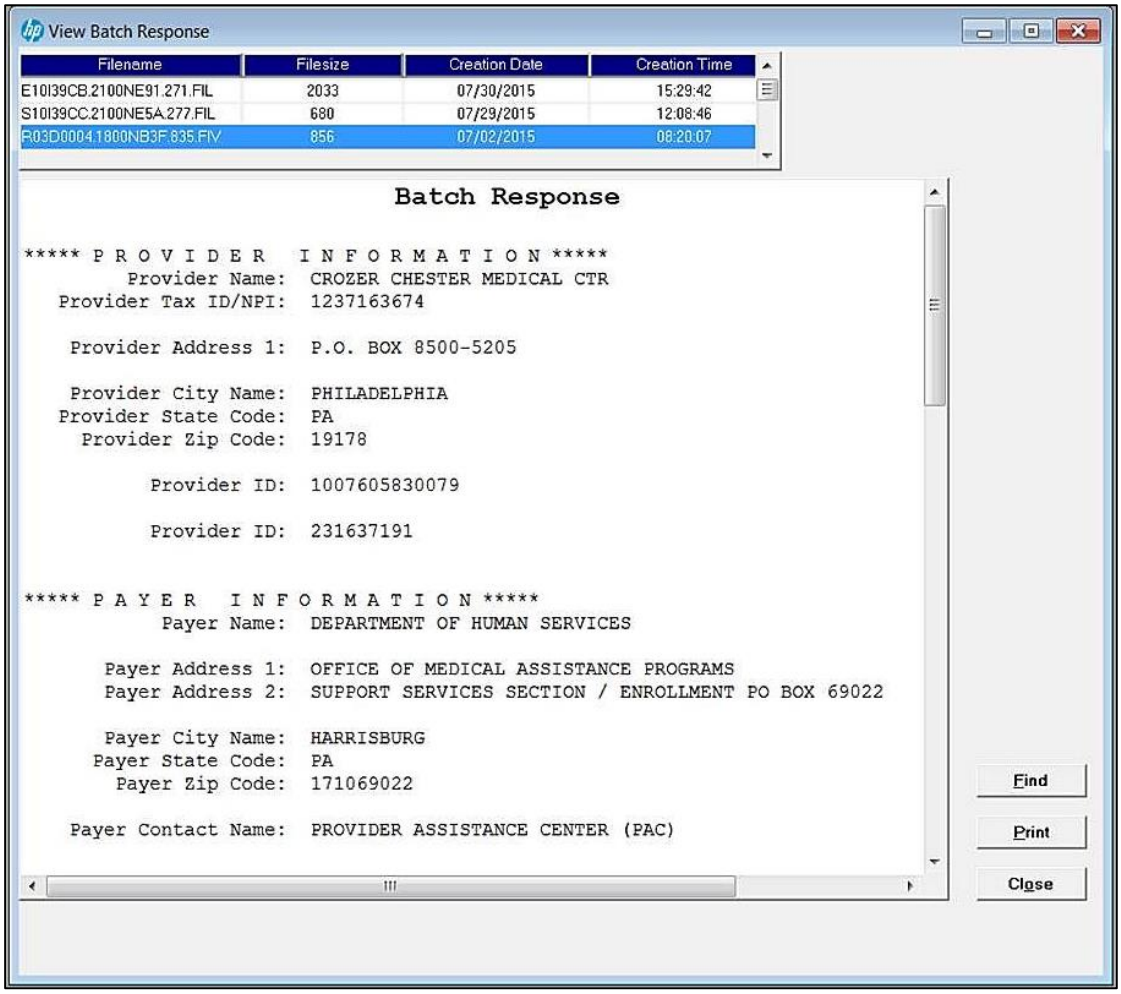


The 835 ERA screen is displayed.

Step 3. Select the file you would like to view.

The contents of the file appear below the list of files.

Step 4. Use the scroll bars (on the left side and at the bottom of the 271 Eligibility Response or 835 ERA) to view the entire report.



Note: In addition the information above, the following will also be on the 835 ERA response:

******* For complete CARC/RARC Descriptions, please visit the following web site: *******

Washington Publishing Company **http://www.wpc-edi.com**

CAQH CORE website **http://www.caqh.org**

Step 5. Click Print to print the 271 Eligibility Response or 835 ERA.

The entire report will print — not just an individual response.

Step 6. Click Close to exit the View Batch Response screen.

10.5 View Bulletins

You can view and print the bulletins that have been posted to the Pennsylvania MA bulletin board. Bulletins are important messages and should be accessed regularly. A sample bulletin is shown below.

Sample Bulletin

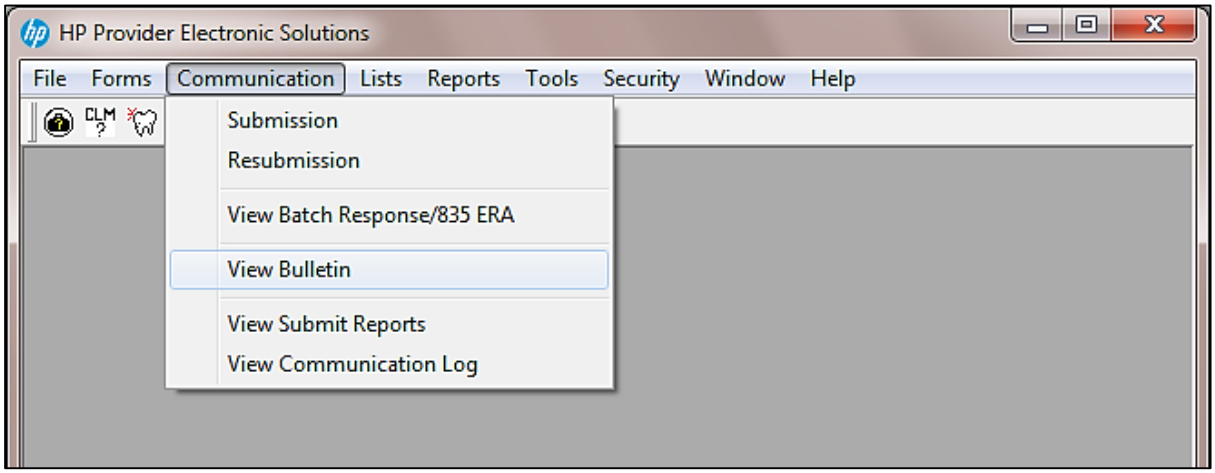
```
******* MESSAGE OF THE DAY *******
From: EMCS SYSOP
The following time limits apply to all files on the BBS:
      Mail                    5 Days
      News (bulletins/Libs)   Not automatically purged
      Files for download      10 Days
      Archives (Upld/Dnld)    1 Day
      Operations Logs         3 Days
Files that are older than the indicated date will be deleted during the nightly batch cycle.
```

Prior to viewing a bulletin, you must retrieve the file using the **Submission** option of the Communications menu found on the Main Menu of the Provider Electronic Solutions software.

To view the bulletins, perform the following steps:

Step 1. Download the bulletin by following the instructions in section 10.1, *Batch Submission*, that discuss how to submit and receive files.

Step 2. Select the **View Bulletin** option from the **Communication** menu to access the Bulletin screen.



The Bulletin screen is displayed.

Step 3. Click Print to print the bulletins.

Step 4. Click Close to exit the Bulletin screen.

10.6 View Submit Reports

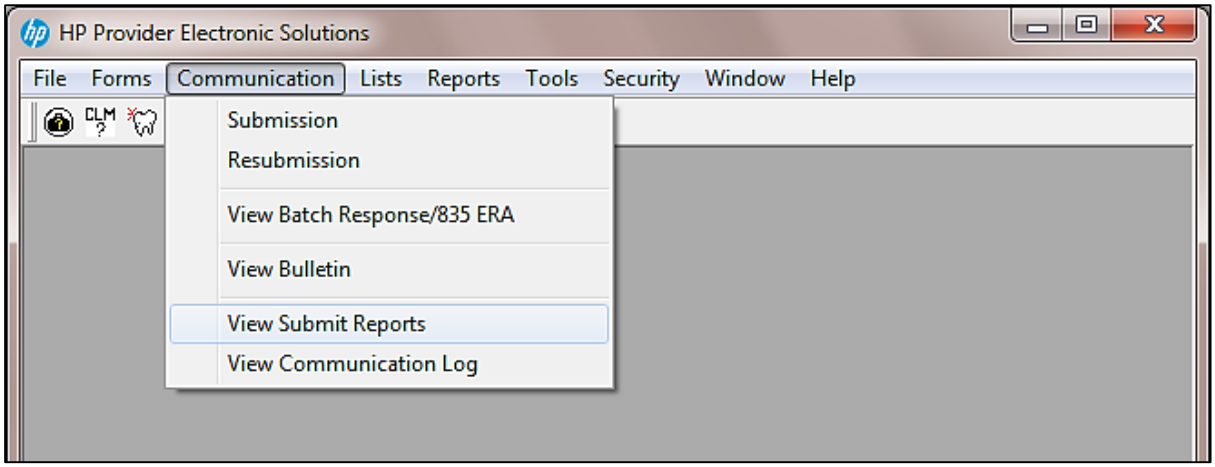
The View Submit Reports option lets you see if the forms in a particular batch have made it through the first level of system edits, and to receive transmission information regarding files. **After you have submitted batch files into the system, you should wait 8 hours before downloading the associated Submit Reports.**

To view the reports, perform the following steps:

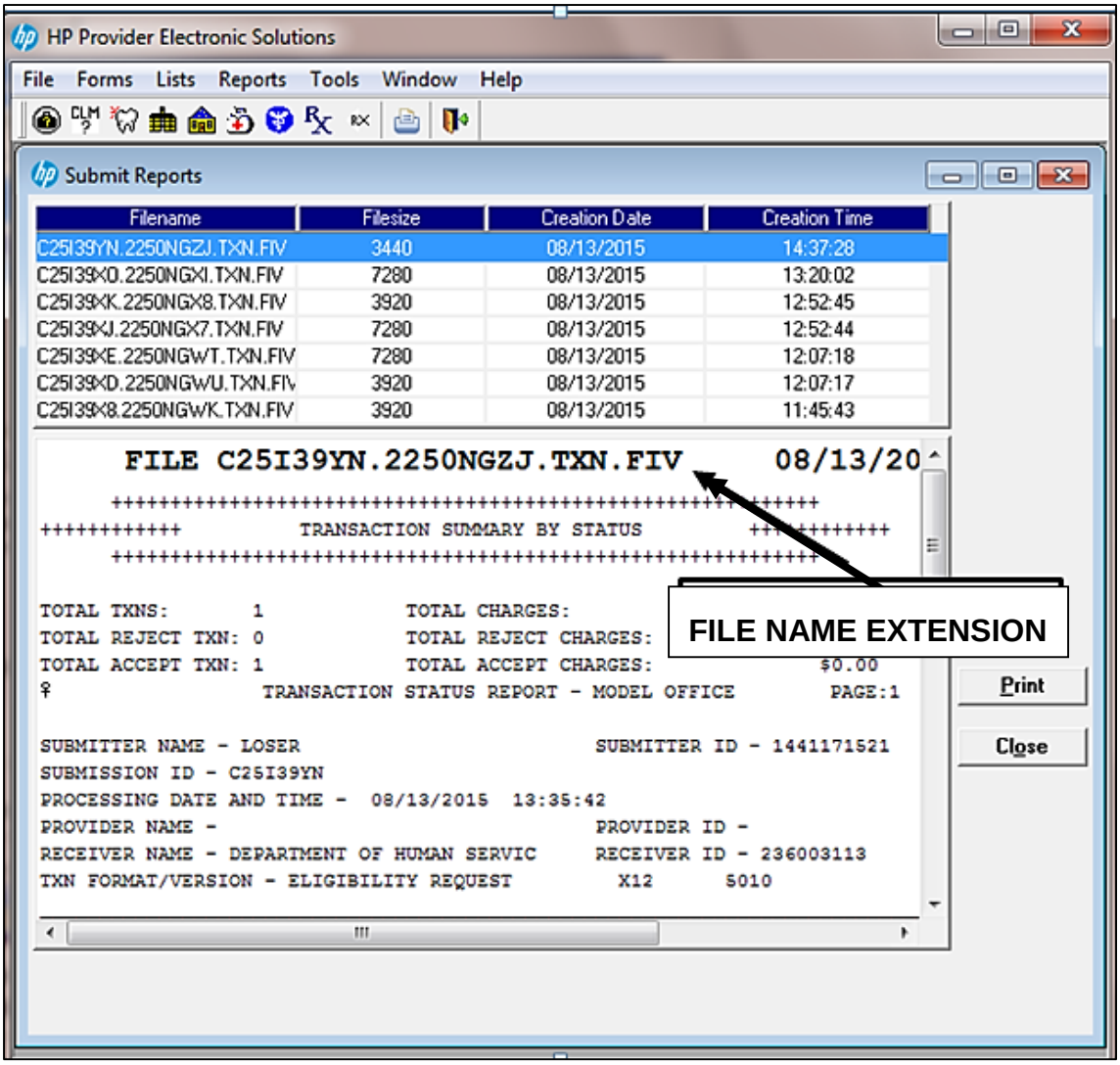
Step 1. Download the reports by following the instructions in section 10.1, *Batch Submission*.

Step 2. Select the **View Submit Reports** option from the **Communication** menu to access the Submit Report screen.

You are responsible for verifying that your claims are accepted for payment. You will not be contacted by HP Enterprise Services if a claim or transaction is rejected.



The Submit Reports screen is displayed.


HP Provider Electronic Solutions
File Forms Lists Reports Tools Window Help
Submit Reports
Filename Filesize Creation Date Creation Time
C25I39YN.2250NGZJ.TXN.FIV 3440 08/13/2015 14:37:28
C25I39XO.2250NGXI.TXN.FIV 7280 08/13/2015 13:20:02
C25I39XK.2250NGX8.TXN.FIV 3920 08/13/2015 12:52:45
C25I39XJ.2250NGX7.TXN.FIV 7280 08/13/2015 12:52:44
C25I39XE.2250NGWT.TXN.FIV 7280 08/13/2015 12:07:18
C25I39XD.2250NGWU.TXN.FIV 3920 08/13/2015 12:07:17
C25I39X8.2250NGWK.TXN.FIV 3920 08/13/2015 11:45:43
FILE C25I39YN.2250NGZJ.TXN.FIV 08/13/20
TRANSACTION SUMMARY BY STATUS
TOTAL TXNS: 1 TOTAL CHARGES:
TOTAL REJECT TXN: 0 TOTAL REJECT CHARGES:
TOTAL ACCEPT TXN: 1 TOTAL ACCEPT CHARGES: $0.00
TRANSACTION STATUS REPORT - MODEL OFFICE PAGE:1
SUBMITTER NAME - LOSER SUBMITTER ID - 1441171521
SUBMISSION ID - C25I39YN
PROCESSING DATE AND TIME - 08/13/2015 13:35:42
PROVIDER NAME - PROVIDER ID -
RECEIVER NAME - DEPARTMENT OF HUMAN SERVIC RECEIVER ID - 236003113
TXN FORMAT/VERSION - ELIGIBILITY REQUEST X12 5010
FILE NAME EXTENSION
Print
Close

The extension in the file name indicates what is contained in the file. The chart that follows provides explanations of each file name extension.

Filename Extensions	
Extension	**Description**
271	Response to a 270 Eligibility Benefit Inquiry transaction that indicates whether the individual is entitled to receive MA benefits.
835	Payment Advice (also referred to as a Remittance Advice), which shows the payment details for your claims submissions.

Filename Extensions	
Extension	**Description**
999	Acknowledgment Report, which indicates that the file sent for processing failed initial HIPAA edits and needs to be resubmitted. Exception: 270 submissions can receive a 999 that does not indicate a failure.
TXN	A Transaction Status Report, which lists those transactions within a batch that were approved and/or rejected. For eligibility inquires, the report contains a list of individuals who are approved and/or rejected for MA services. For claims, the report lists the transactions that passed and/or failed the HIPAA checks. Failed transactions need to be corrected, and then resubmitted. **Note:** Payment is not guaranteed for claims that are accepted on this report.
NCP	Response to a NCPDP (pharmacy) claim that was submitted for processing, which indicates whether the claim was accepted and processed, or rejected.
ZZZ	Unrecognizable File Format Report, which indicates that the associated transmission was garbled or corrupted.

Step 3. Click

to print the reports.

Step 4. Click

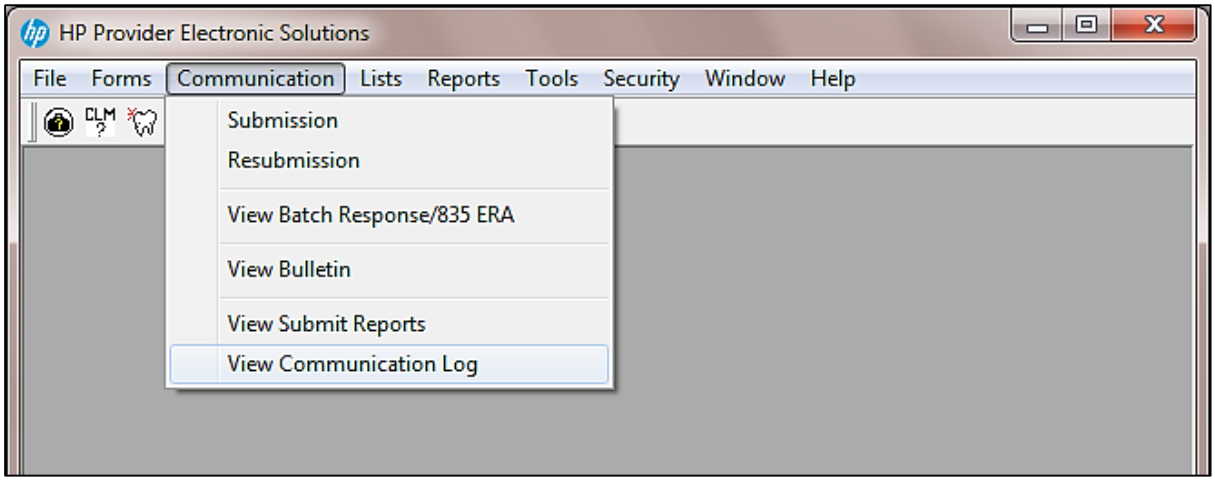
to exit the Submit Reports Screen.

10.7 View Communication Logs

The Communication Logs list the batch files submitted to HP Enterprise Services, and include their file size, creation date, creation time, and submission information.

To view the communications logs, perform the following steps:

Step 1. Select the **View Communication Log** option from the **Communication** menu to access the Communication Log screen

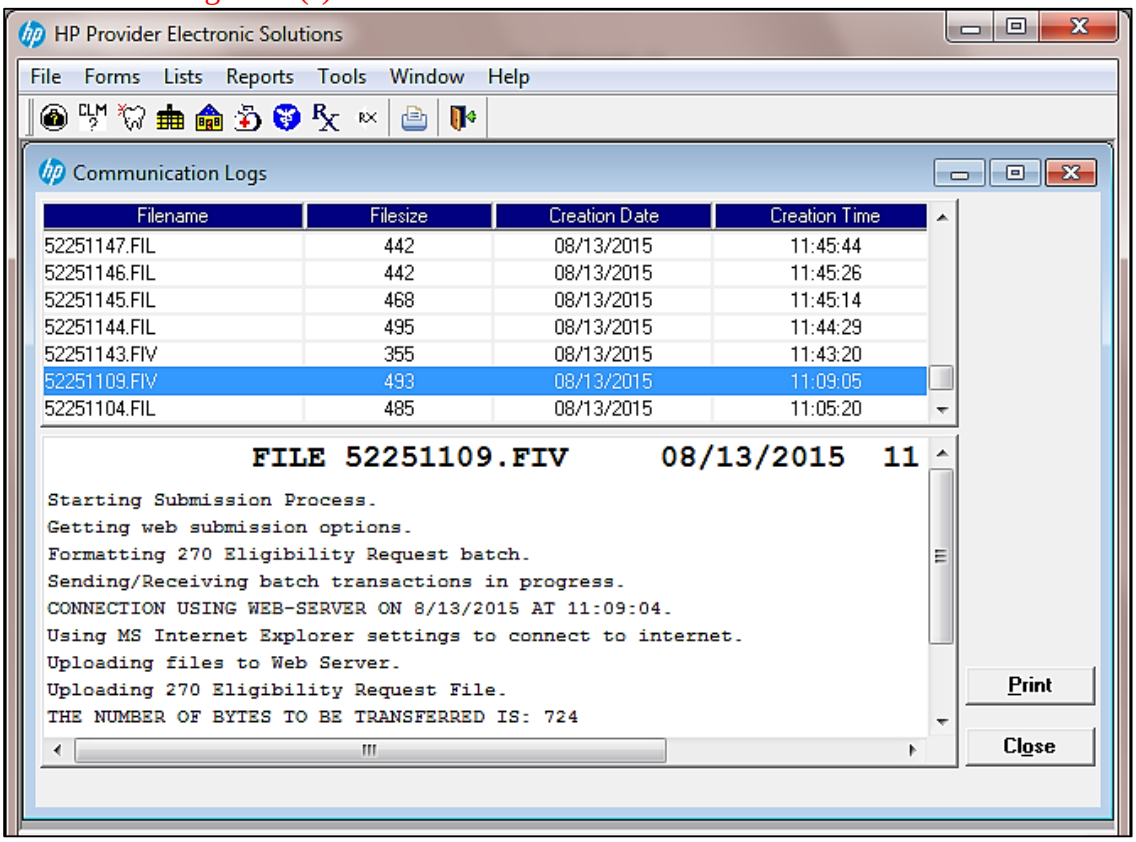


The Communication Logs screen is displayed.

Step 2. Click on a batch record to select it and display its submission information.

The batch, shown below, was submitted successfully.

Note: Submitted successfully does not necessarily mean that the files submitted were processed successfully into the PROMISe system. You must download and review the following reports for any files that may have rejected for HIPAA errors: Submission Transaction Report(s), Accepted Submit Report(s) and the Rejected Submit Report(s) and 999 Acknowledgement(s)



Step 3. Click

to print the Communication Log.

Step 4. Click

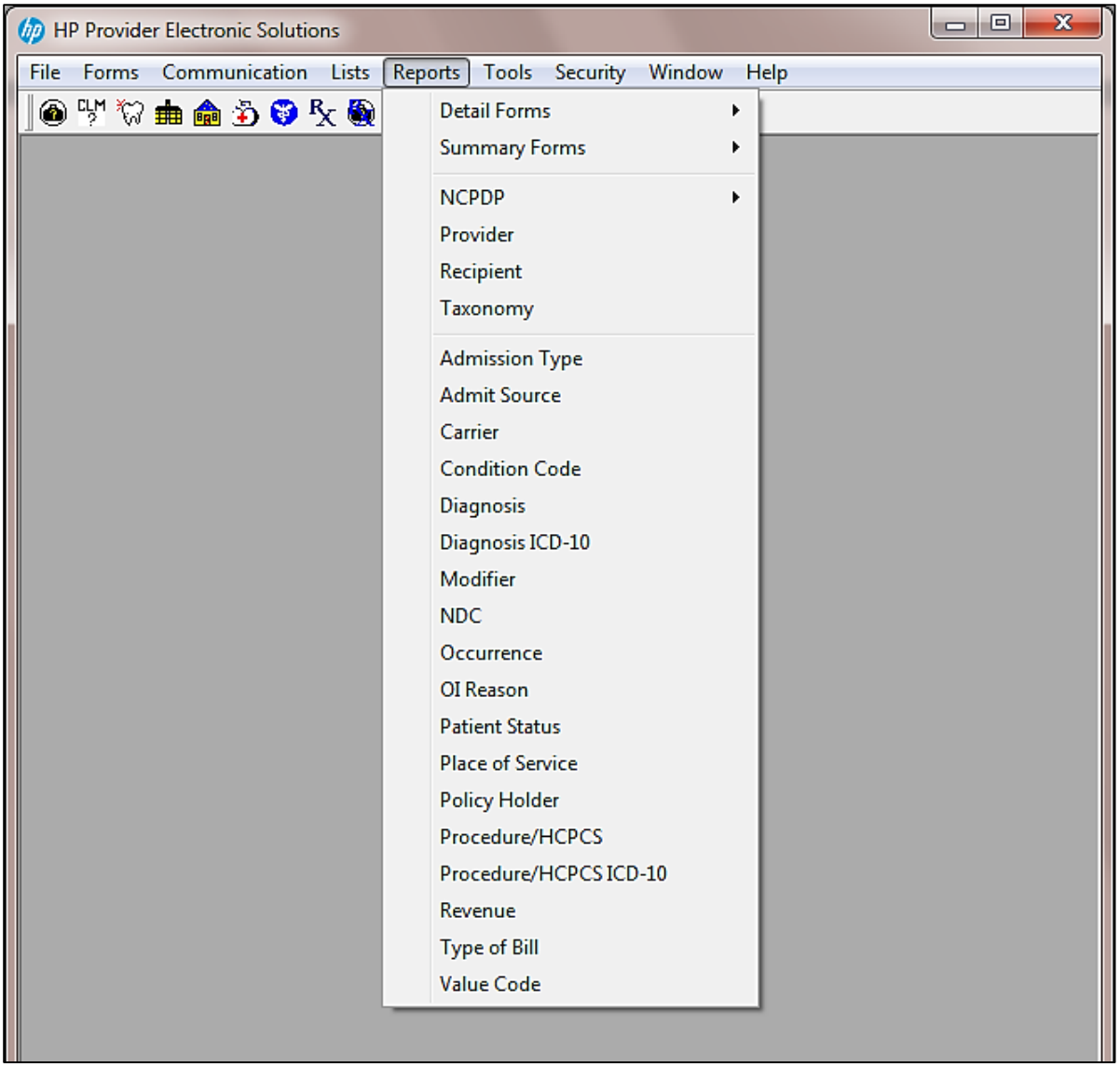
to exit the Communication Log screen.

11 Accessing and Using Reports

The Provider Electronic Solutions software lets you create and print reports, as well as view and print all the selections contained in a reference list. The table below describes the type of information that can be viewed from the options in the Reports menu.

Detail Form Report	This type of report retrieves and displays the form information from the Form screens so you can view all the information that has been entered for the selected form.
Summary Form Report	This type of report displays basic recipient information, the billed amount, the date the form was last submitted, status, and service lines.
Reports Menu	This option allows you to access a Reference list, and view and print a master list of the selections for that reference list.

You can access these reports from the **Reports** drop down menu, located on the main menu of the Provider Electronic Solutions software.



11.1 270 Eligibility Request Detail Report

You can generate a detail report for the 270 Eligibility Request(s) using the Provider Electronic Solutions software. This detail report contains only the key fields on the 270 Eligibility Request Form.

To generate a 270 Eligibility Request Detail Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **270 Eligibility Request** option from the **Detail Forms** drop down menu.

Step 2. The 270 Eligibility Request Detail Report screen is displayed.

Step 3. Click OK to include all the requests in the detail report.

Step 4. Click OK. When you see the box advising you that all records will be selected. A detailed report is generated and displayed on your screen.

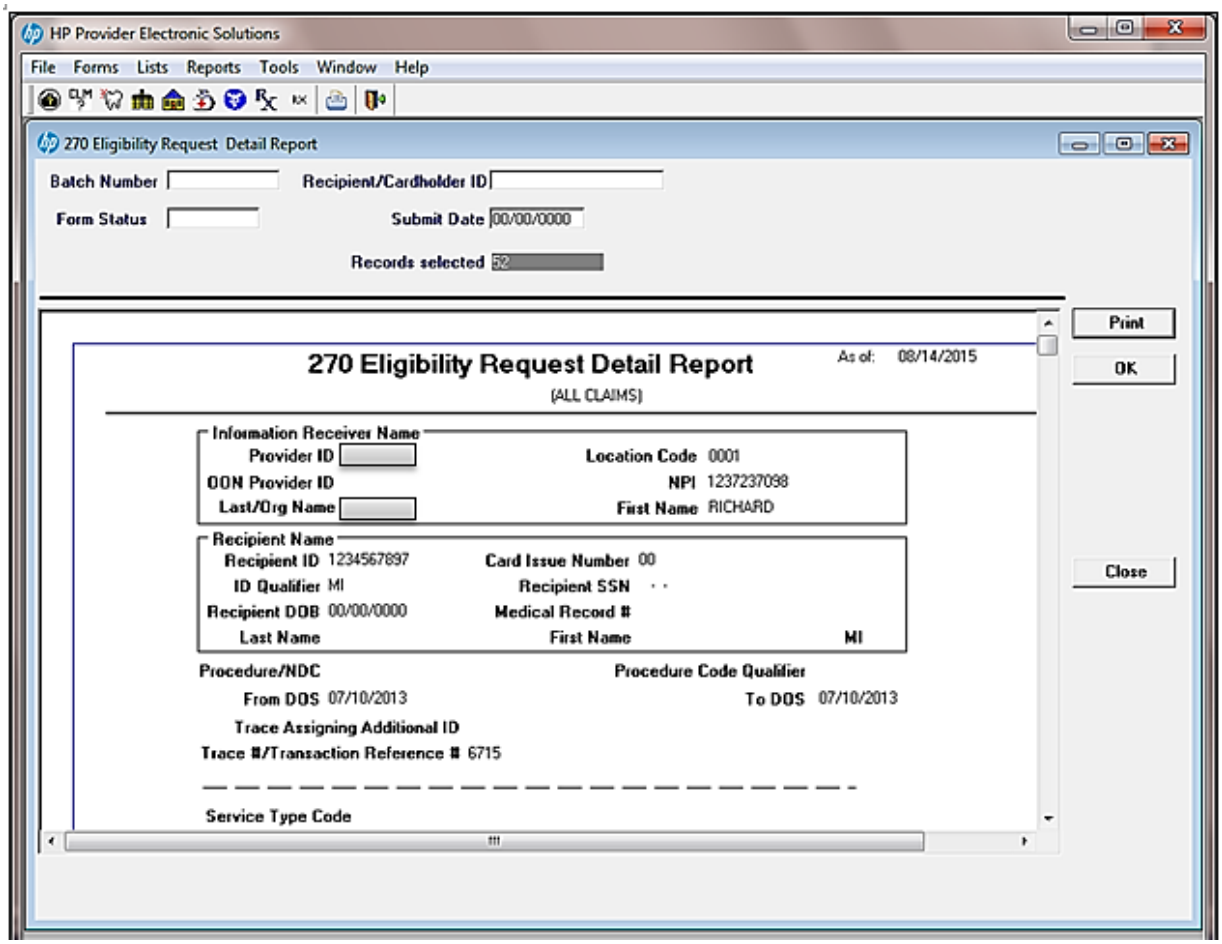
To limit the type of requests in the detail report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the detail report to requests in a specific batch. Enter the appropriate batch ID number in this field. You can locate the batch numbers under the Resubmission or the Communication Log options of the View Communication Log menu.
Recipient/ Cardholder ID	Limits the detail report being requested to return information only for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the detail report being requested to include only the claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the detail report to requests transmitted on the specified date. Enter the appropriate date in this field.

Step 5. After you enter the report criteria, click OK.

The detail report is generated and is displayed on your screen.

Step 6. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 7. Click **Print** to print the 270 Eligibility Request Detail Report.

Step 8. Click **Close** to exit the 270 Eligibility Request Detail Report screen.

11.2 270 Eligibility Request Summary Report

You can generate a summary report for 270 Eligibility Request(s) using the Provider Electronic Solutions software. This summary report contains only the key fields on the 270 Eligibility Request form.

To generate a 270 Eligibility Request Summary Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **270 Eligibility Request** option from the **Summary Forms** drop down menu.

The 270 Eligibility Request Summary Report screen is displayed.

Step 2. Click **OK** to include all the requests in the summary report.

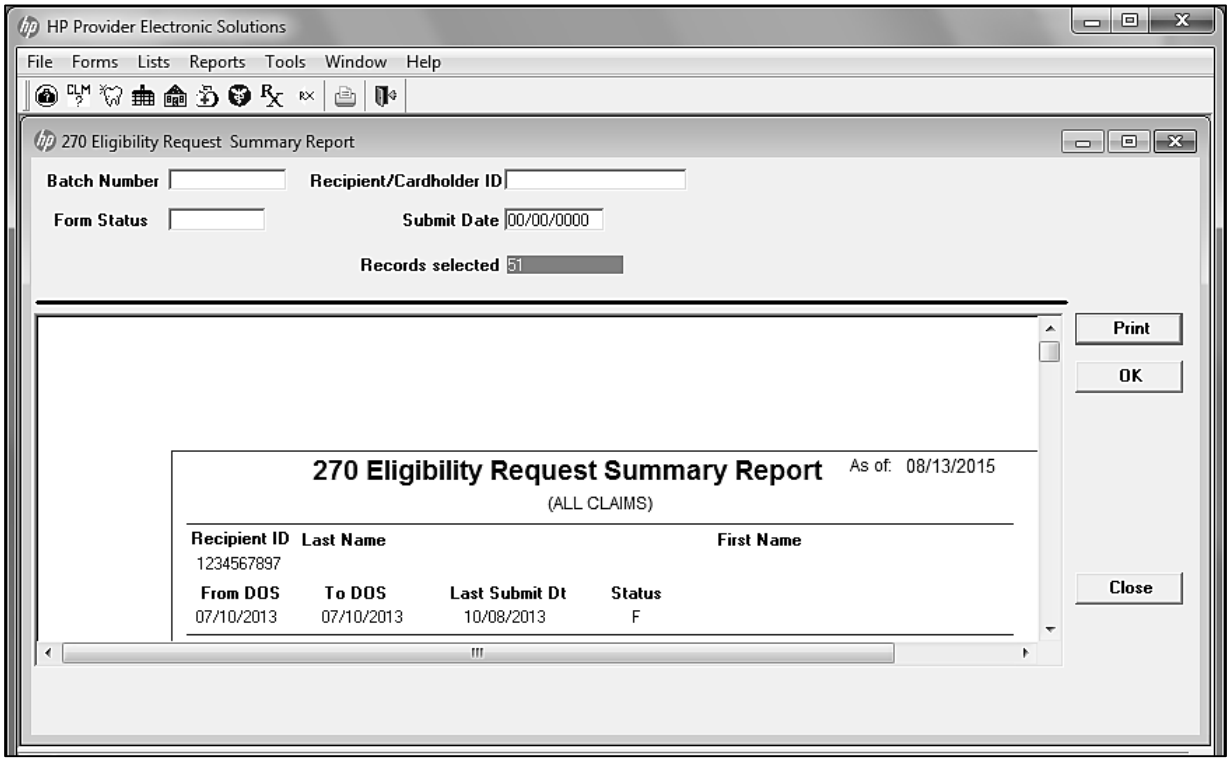
Step 3. Click **OK** when prompted by the box that advises you that all records will be selected. A detailed report will then generate and display on your screen.

Step 4. Enter the appropriate report criteria into one or more of the following fields to limit the type of request in the summary report:

Batch Number	Limits the summary report to requests in a specific batch. Enter the appropriate batch ID number in this field. You can locate the Batch Numbers under the Resubmission Option of the Communications Menu.
Recipient/ Client ID	Limits the summary report being requested to return information only for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report being requested to include only the claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to requests transmitted on the specified date. Enter the appropriate date in this field.

Step 5. After you enter the report criteria, click OK. The summary report is generated and displayed.

Step 6. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 7. Click Print to print the 270 Eligibility Request Summary Report.

Step 8. Click Close to exit the 270 Eligibility Request Summary Report screen.

11.3 276 Claim Status Detail Report

You can generate a detail report for a Claim Status Request using the Provider Electronic Solutions software. The detail report contains all the fields on the 276 Claim Status Request Form.

To generate a 276 Claim Status Request Detail Report perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **276 Claim Status** option from the **Detail Forms** menu.

The 276 Claim Status Request Detail Report screen is displayed.

Step 2. Click OK to include all the requests in the summary report.

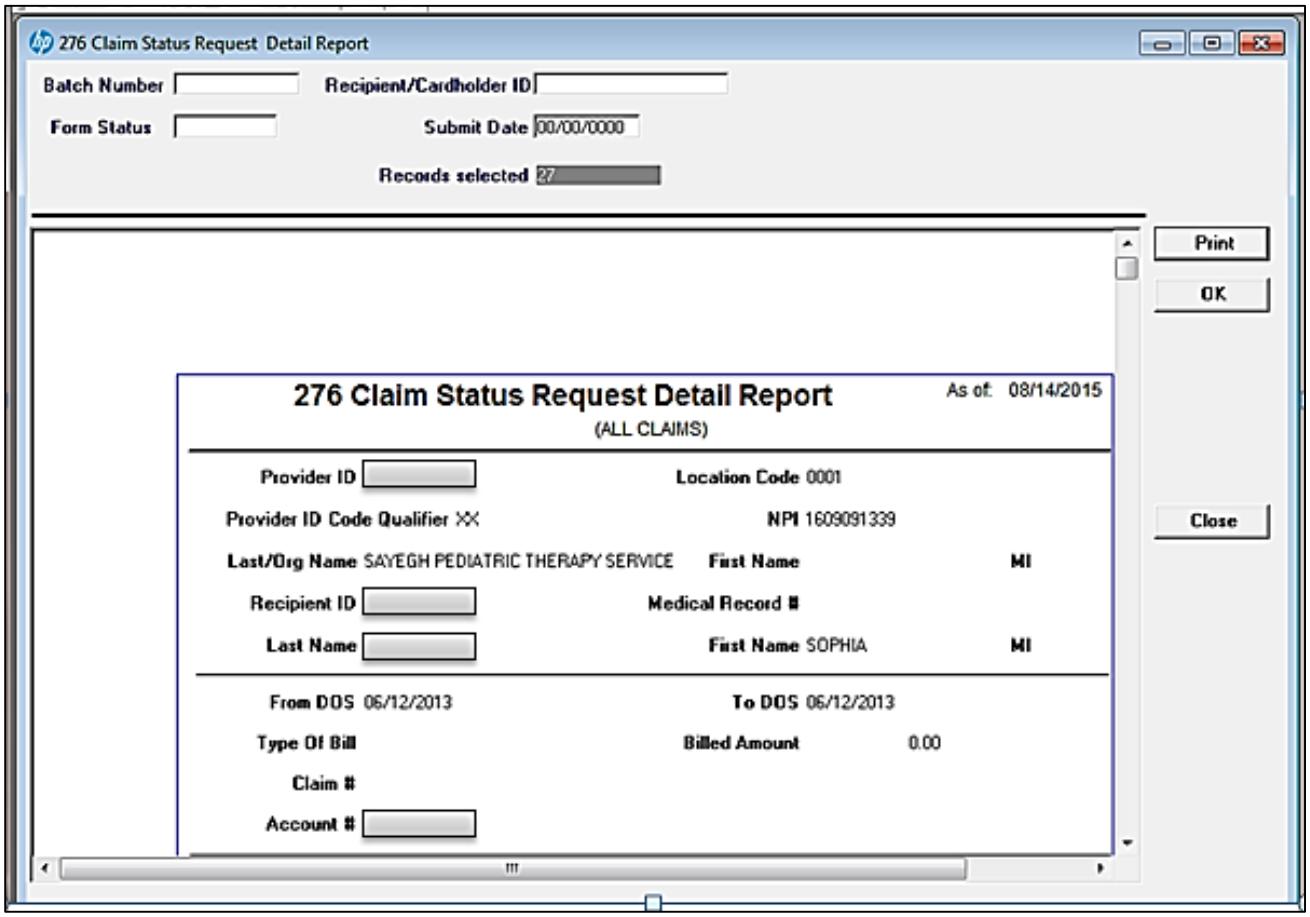
Step 3. Click OK when prompted by the box that advises you that all records will be selected. A detail report is then generated and displayed on your screen.

To limit the type of request in the detail report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the detail report to requests in a specific batch. Enter the appropriate batch ID number in this field. You can locate the batch numbers under the Resubmission option of the View Communications Log menu.
Recipient/ Cardholder ID	Limits the detail report being requested to return information only for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the detail report being requested to include only the claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the detail report to requests transmitted on the specified date. Enter the appropriate date in this field.

Step 4. Click OK after you enter the report criteria. A summary report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 276 Claim Status Request Detail Report.

Step 7. Click Close to close the Detail Report screen.

11.4 276 Claim Status Summary Report

You can generate a summary report for a Claim Status Request using the Provider Electronic Solutions software. This summary report contains only the key fields on the 276 Claim Status Request Form.

To generate a 276 Claim Status Request Summary Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the 276 Claim Status option from the Detail Forms menu.

The 276 Claim Status Request Summary Report screen is displayed.

Step 2. Click OK to include all the requests in the summary report.

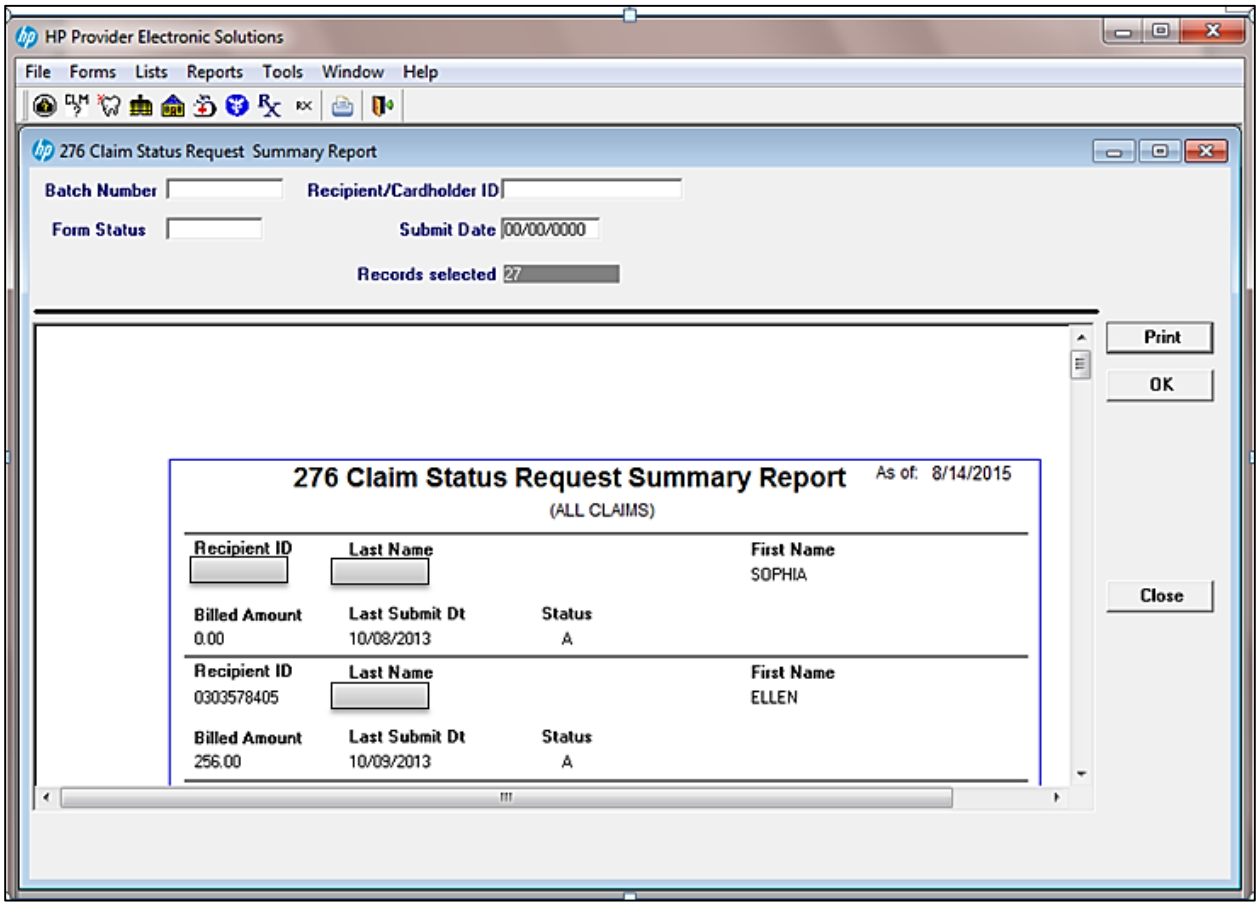
Step 3. Click OK when prompted by the box that advises you that all records will be selected. A detailed report is generated and displayed on your screen.

To limit the type of request in the summary report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to requests in a specific batch. Enter the appropriate batch ID number in this field. You can locate the batch numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Cardholder ID	Limits the summary report being requested to return information only for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report being requested to include only the claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to requests transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK. The summary report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 276 Claim Status Request Summary Report.

Step 7. Click Close to close the Summary Report screen.

11.5 837 Dental Detail Report

You can generate a detail report for a Dental Claim using the Provider Electronic Solutions software. This detail report contains all the fields on the 837 Dental form.

To generate an 837 Dental Detail Report, perform the following steps:

Step 1. From the main screen of Provider Electronic Solutions software, select the **837 Dental** option from the **Detail Forms** drop down menu.

837 Dental Detail Report screen is displayed.

Step 2. Click OK to include all the Dental Claims in the detail report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A detailed report is generated and displayed on your screen.

To limit the type of Dental Claims in the detail report, enter the appropriate report criteria into one or more of the following fields:

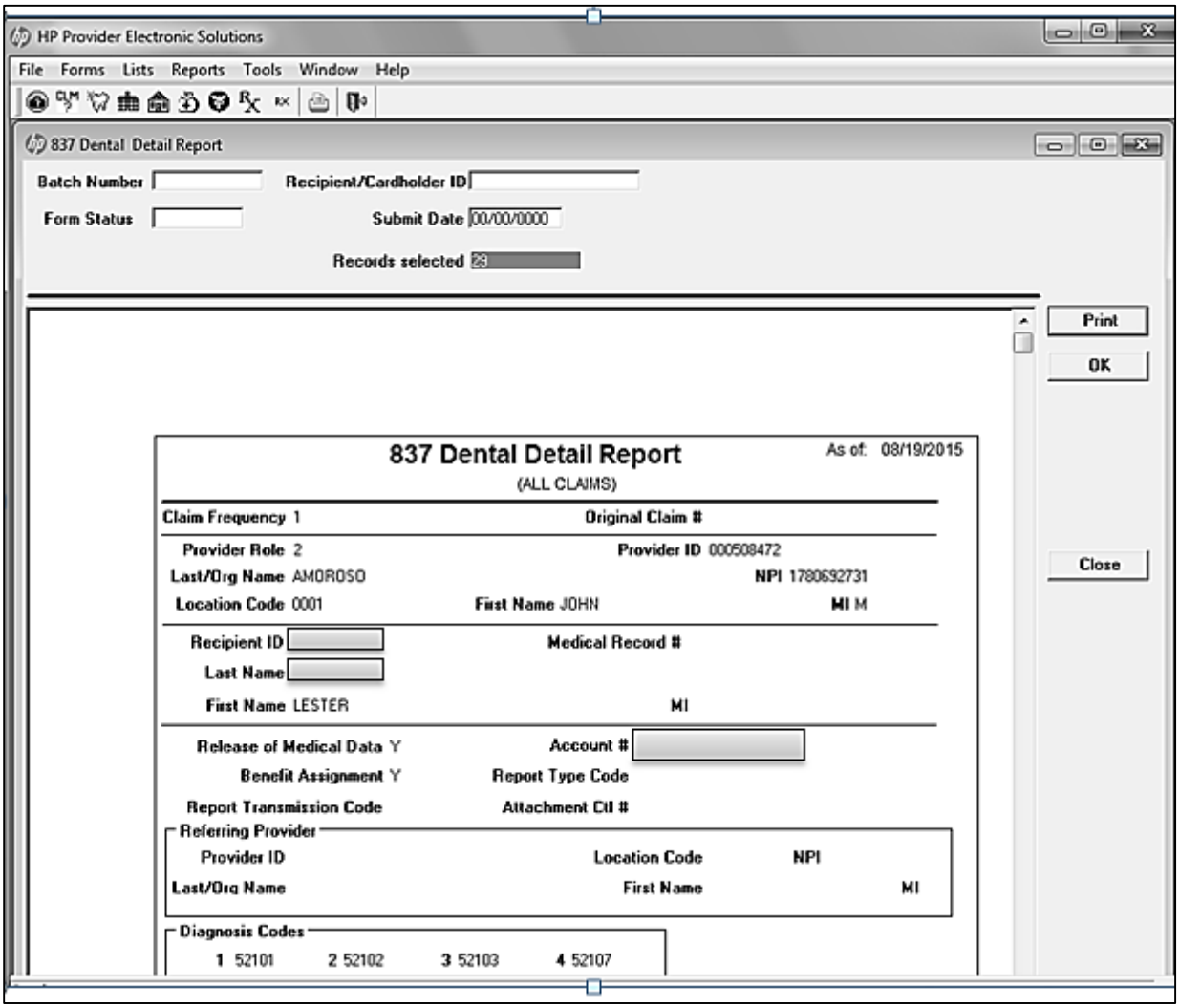
Batch Number	Limits the detail report to Dental Claims in a specific batch. Enter the appropriate batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Cardholder ID	Limits the detail report to information for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to include only the claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Dental Claims transmitted on a specified date. Enter the appropriate date in this field.

Step 4. Click

after you enter the report criteria.

A detailed report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 837 Dental Detail Report.

Step 7. Click Close to exit the 837 Dental Detail Report screen.

11.6 837 Dental Summary Report

You can generate a summary report for a Dental Claim using the Provider Electronic Solutions software. The summary report contains only the key fields on the 837 Dental Form.

To generate an 837 Dental Summary Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **837 Dental** option from the **Summary Forms** drop down menu.

The 837 Dental Summary Report screen is displayed.

Step 2. Click OK to include all the Dental Claims in the summary report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A summary report is generated and displayed on your screen.

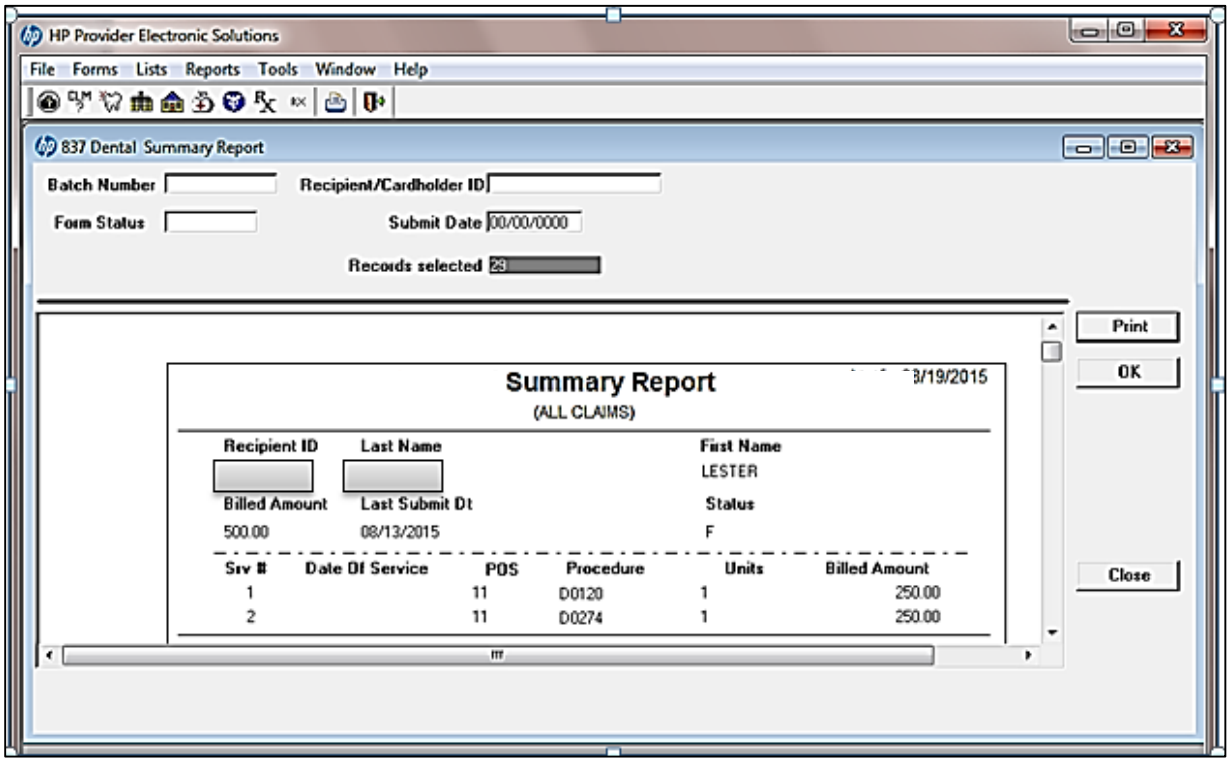
To limit the type of Dental Claims in the summary report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to Dental Claims in a specific batch. Enter the appropriate Batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Client ID	Limits the summary report of Dental Claims being requested for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Dental Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report of Dental Claims transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The summary report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 837 Dental Summary Reports.

Step 7. Click Close to exit the 837 Dental Summary Report screen.

11.7 837 Institutional Inpatient Detail Report

You can generate a detail report 837 Institutional Inpatient Claims using the Provider Electronic Solutions software. This detail report contains all the fields on the 837 Institutional Inpatient form.

To generate an 837 Institutional Inpatient Detail Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **837 Institutional Inpatient** option from the **Detail Forms** drop down menu.

The 837 Institutional Inpatient Detail Report screen is displayed.

Step 2. Click OK to include all the Inpatient Claims in the detail report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A detailed report is generated and displayed on your screen.

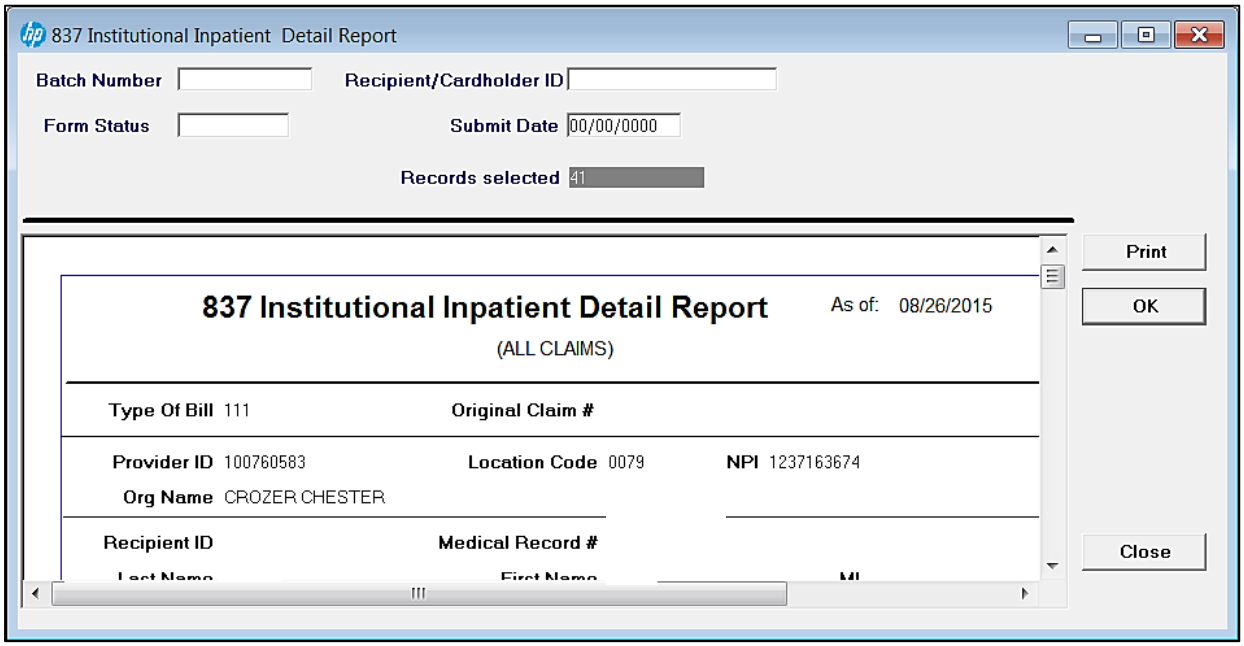
To limit the type of Inpatient Claims in the detail report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to Inpatient Claims in a specific batch. Enter the appropriate batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Cardholder ID	Limits the summary report to Inpatient Claims for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Inpatient Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Inpatient Claims transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The detailed report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 837 Institutional Inpatient Detail Report.

Step 7. Click Close to exit the 837 Institutional Inpatient Detail Report screen.

11.8 837 Institutional Inpatient Summary Report

You can generate a summary report for the Institutional Inpatient Claims using the Provider Electronic Solutions software. This summary report contains only the key fields on the 837 Institutional Inpatient Form.

To generate an 837 Institutional Inpatient Summary Report, perform the following steps:

Step 1. From the main menu of the Provider Electronic Solutions software, select the **837 Institutional Inpatient** Option from the **Summary Forms** drop down menu.

The 837 Institutional Inpatient Summary Report screen is displayed.

Step 2. Click OK to include all the Inpatient Claims in the summary report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A summary report is generated and displayed on your screen.

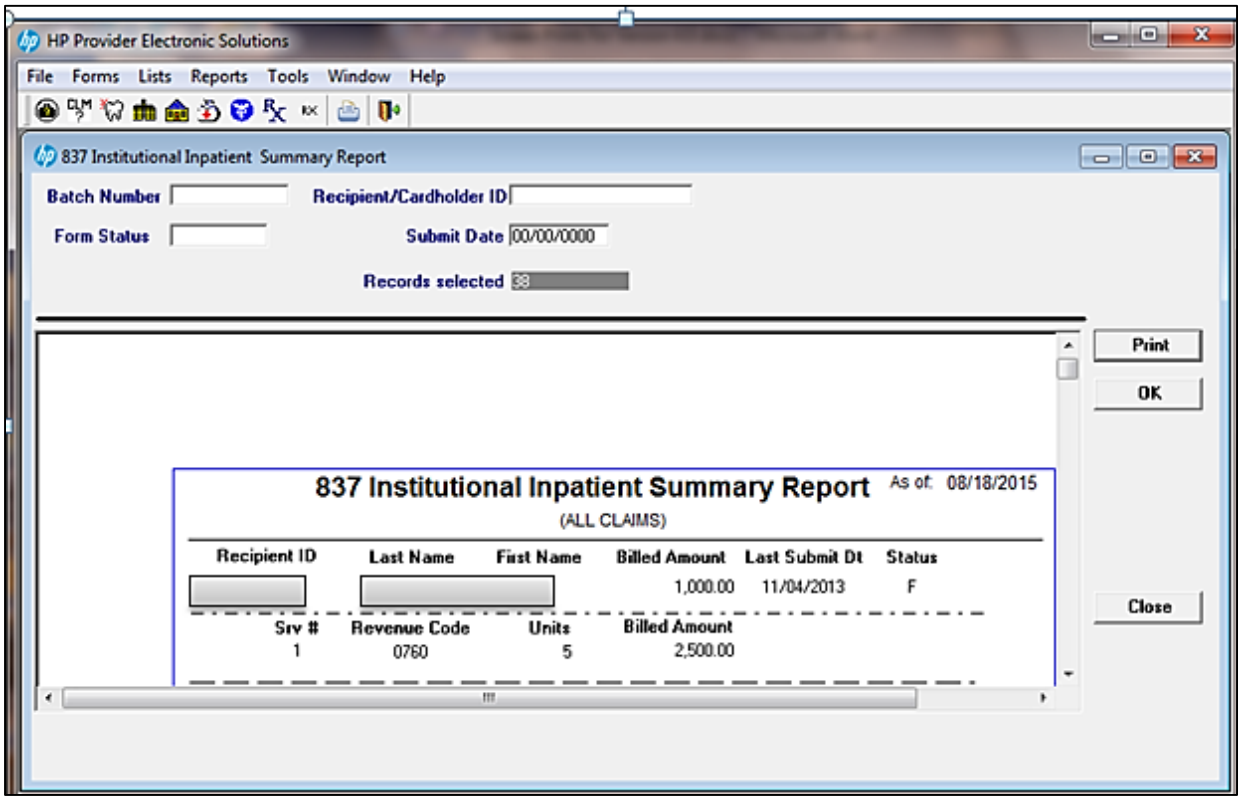
To limit the type of Inpatient Claims in the summary report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to Inpatient Claims in a specific batch. Enter the appropriate Batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Client ID	Limits the summary report to Inpatient Claims for the specified recipient... Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Inpatient Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Inpatient Claims transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The summary report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 837 Institutional Inpatient Summary Report.

Step 7. Click Close to exit the 837 Institutional Inpatient Summary Report screen.

11.9 837 Institutional Nursing Home Detail Report

You can generate a detail report for Institutional Nursing Home Claims using the Provider Electronic Solutions software. This detail report contains all the fields on the 837 Institutional Nursing Home Form.

To generate an 837 Institutional Nursing Home Detail Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **837 Institutional Nursing Home** option from the **Detail Forms** drop down menu.

Batch Number	Limits the summary report to Nursing Home Claims in a specific batch. Enter the appropriate Batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.

Recipient/ Cardholder ID	Limits the summary report to Nursing Home Claims for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Nursing Home Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Nursing Home Claims transmitted on the specified date. Enter the appropriate date in this field.

The 837 Institutional Nursing Home Detail Report screen is displayed.

Step 2. Click OK to include all the Nursing Home Claims in the detail report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

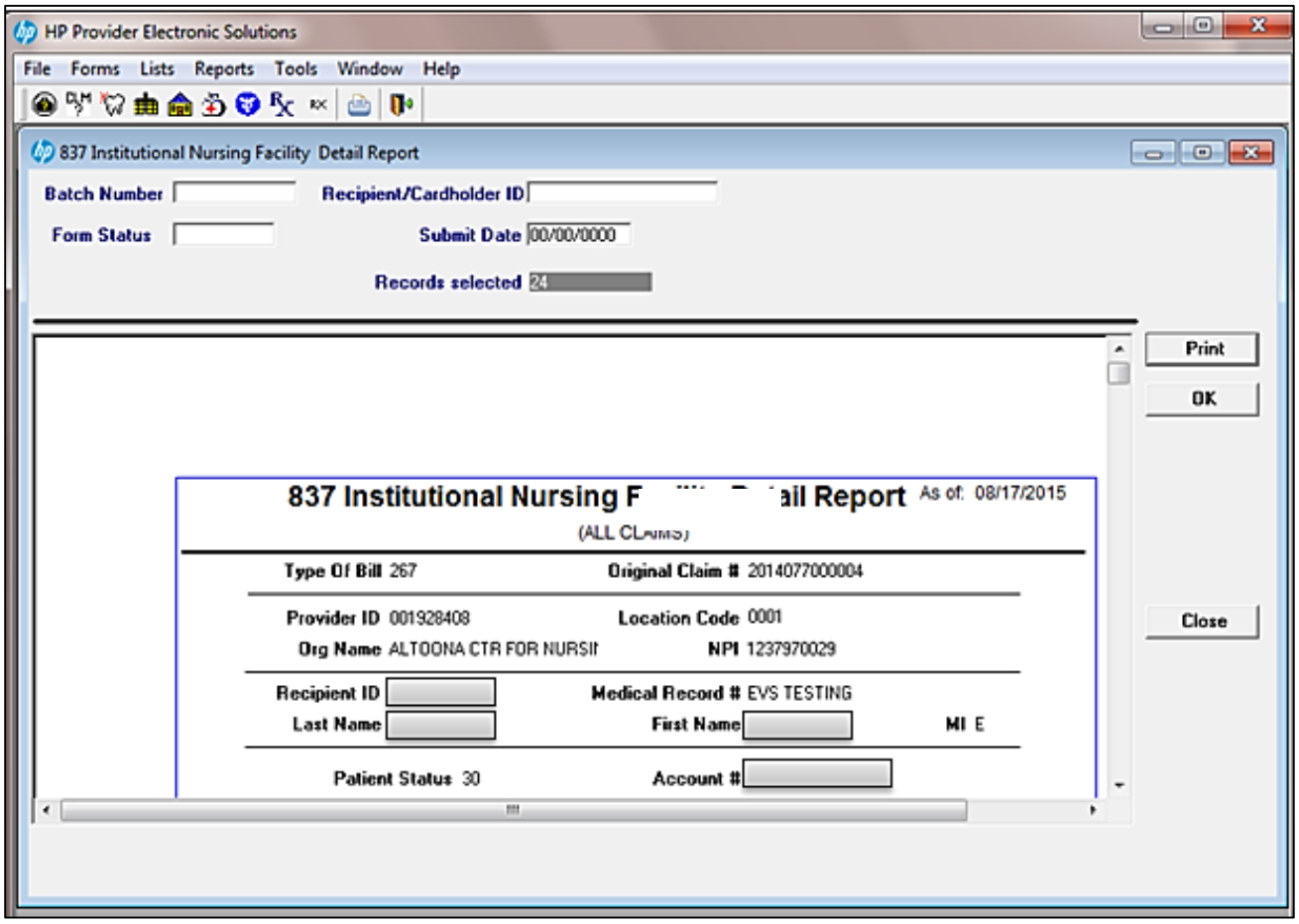
A detailed report is generated and displayed on your screen.

To limit the type of Nursing Home Claims in the detail report, enter the appropriate report criteria into one or more of the following fields:

Step 4. After you enter the report criteria, click OK.

The detailed report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 837 Institutional Nursing Home Detail Report.

Step 7. Click Close to exit the 837 Institutional Nursing Home Detail Report screen.

11.10 837 Institutional Nursing Home Summary Report

You can generate a summary report for Institutional Nursing Home Claims using the Provider Electronic Solutions software. This summary report contains only the key fields on the 837 Institutional Nursing Home form.

To generate an 837 Institutional Nursing Home Summary Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **837 Institutional Nursing Home** option from the **Summary Forms** drop down menu.

The 837 Institutional Nursing Home Summary Report Screen is displayed.

Step 2. Click OK to include all the Nursing Home Claims in the summary report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A summary report is generated and displayed on your screen.

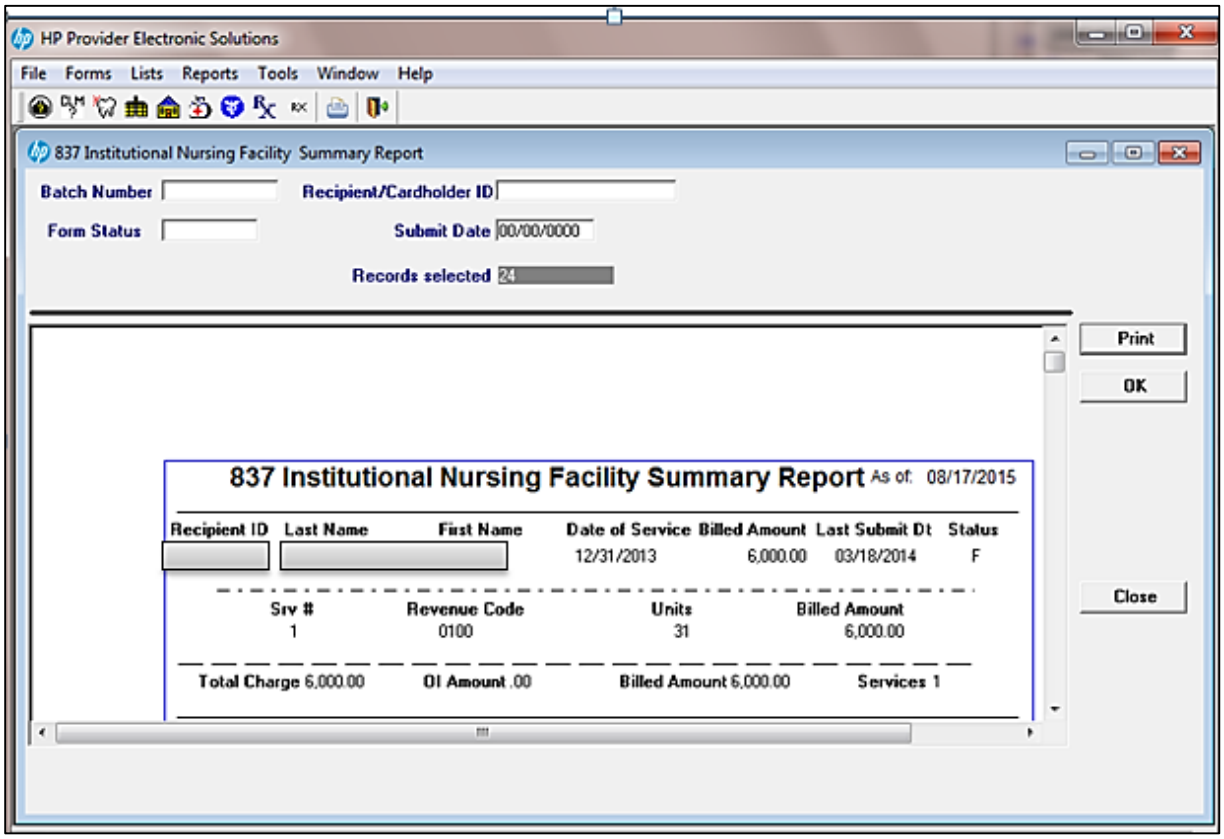
To limit the type of Nursing Home Claims in the summary report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to Nursing Home Claims in a specific batch. Enter the appropriate Batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Cardholder ID	Limits the summary report to Nursing Home Claims for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Nursing Home Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Nursing Home Claims transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The summary report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.


HP Provider Electronic Solutions
File Forms Lists Reports Tools Window Help
837 Institutional Nursing Facility Summary Report
Batch Number
Recipient/Cardholder ID
Form Status
Submit Date 00/00/0000
Records selected 24
Print
OK
837 Institutional Nursing Facility Summary Report As of: 08/17/2015
Recipient ID Last Name First Name Date of Service Billed Amount Last Submit Dt Status
12/31/2013 6,000.00 03/18/2014 F
Srv # Revenue Code Units Billed Amount
1 0100 31 6,000.00
Total Charge 6,000.00 OI Amount .00 Billed Amount 6,000.00 Services 1
Close

Step 6. Click Print to print the 837 Institutional Nursing Home Summary Report.

Step 7. Click Close to exit the 837 Institutional Nursing Home Summary Report screen.

11.11 837 Professional Detail Report

You can generate a detail report for Professional Claims using the Provider Electronic Solutions software. The detail report contains all the fields on the 837 Professional Form.

To generate an 837 Professional Detail Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **837 Professional** Option from the **Detail Forms** drop down menu.

The 837 Professional Detail Report screen is displayed.

Step 2. Click OK to include all the Professional Claims in the detail report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

The detailed report is generated and displayed on your screen.

To limit the type of Professional Claims in the detail report, enter the appropriate report criteria into one or more of the following fields:

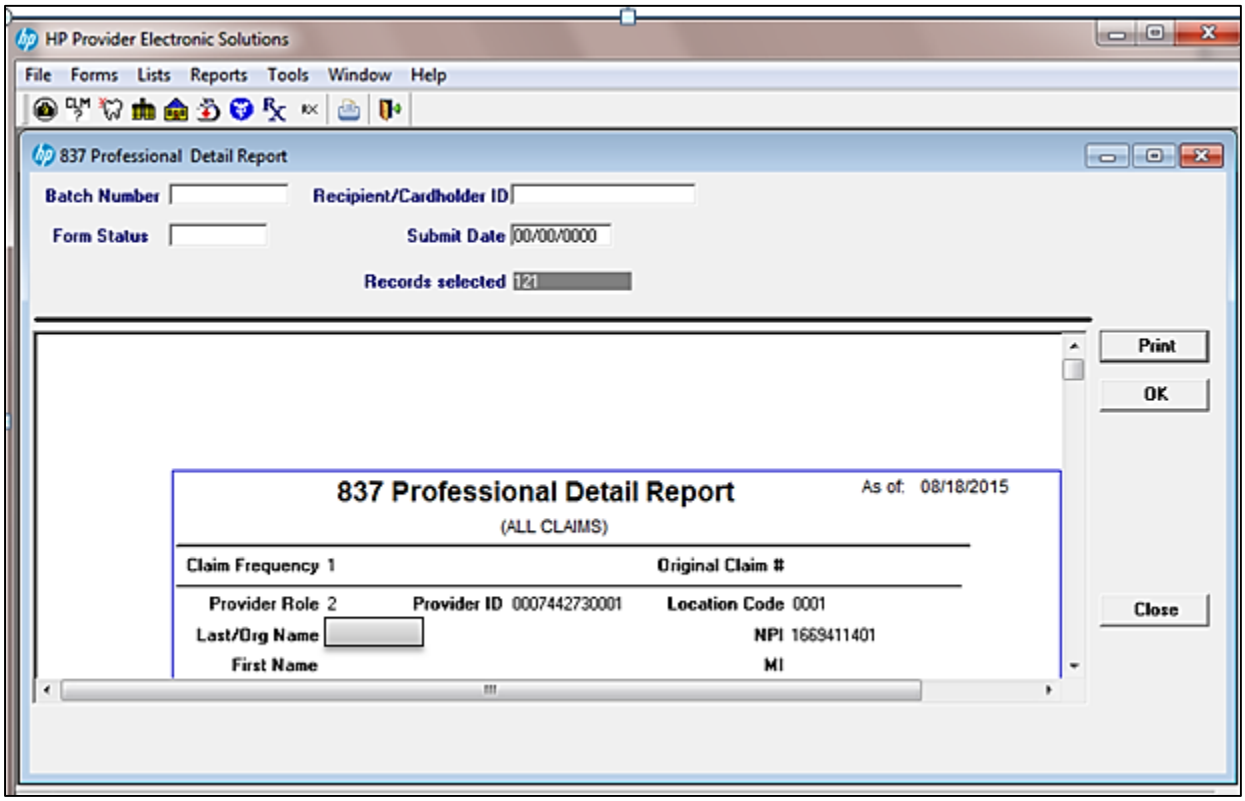
Batch Number	Limits the summary report to Professional Claims in a specific batch. Enter the appropriate batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Cardholder ID	Limits the summary report to Professional Claims for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Professional Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Professional Claims transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click

.

The detailed report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 837 Professional Detail Report.

Step 7. Click Close to exit the 837 Professional Detail Report screen.

11.12 837 Professional Summary Report

You can generate a summary report for a Professional Claim(s) using the Provider Electronic Solutions software. This summary report contains only the key fields on the 837 Professional Form.

To generate an 837 Professional Summary Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **837 Professional** option from the **Summary Forms** drop down menu.

The 837 Professional Summary Report screen is displayed.

Step 2. Click OK to include all the Professional Claims in the summary report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

The summary report is generated and displayed on your screen.

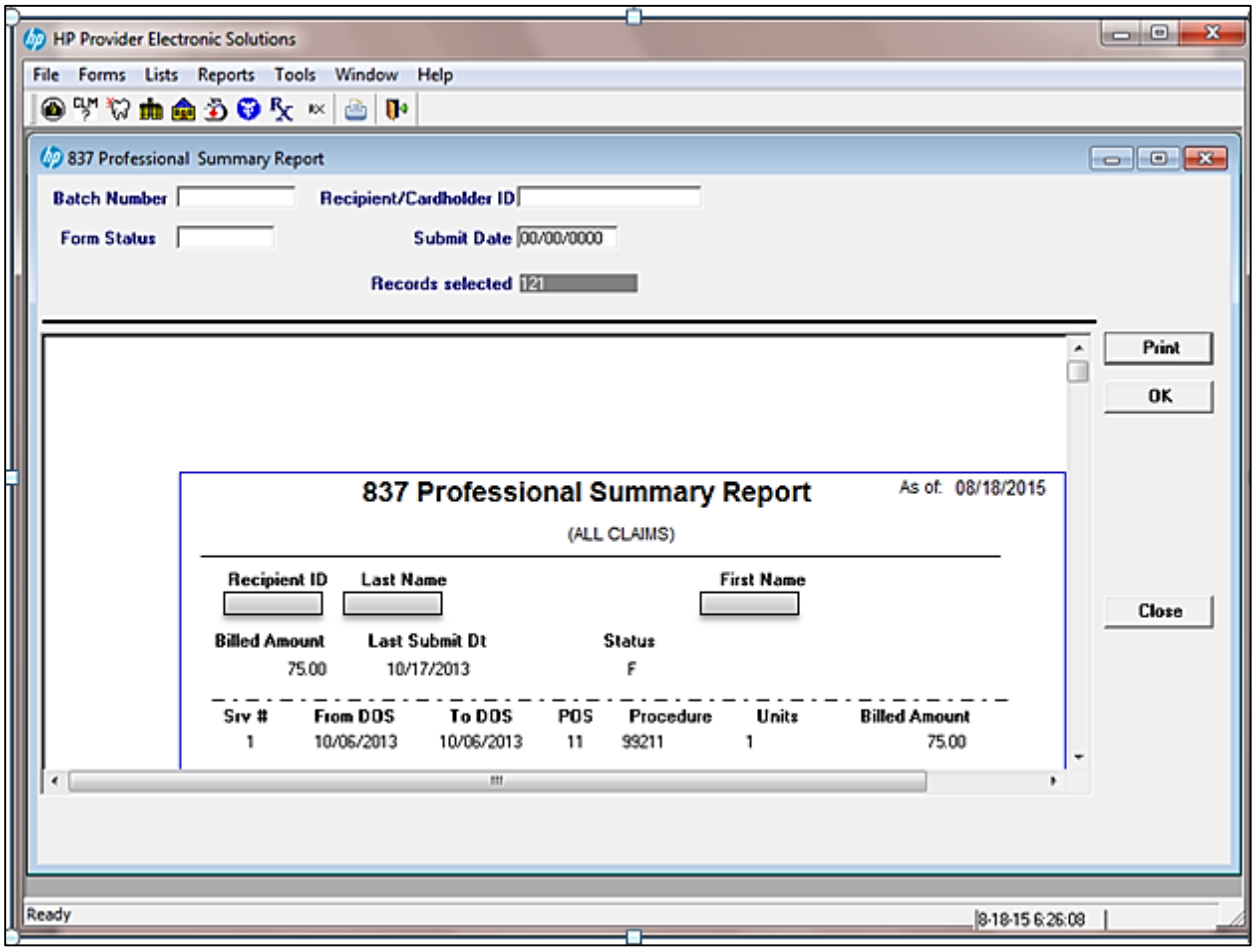
To limit the type of Professional Claims in the summary report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to Professional Claims in a specific batch. Enter the appropriate batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Client ID	Limits the summary report to Professional Claims for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Professional Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Professional Claims transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The summary report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the 837 Professional Summary Report.

Step 7. Click Close to exit the 837 Professional Summary Report screen.

11.13 NCPDP Pharmacy Detail Report

You can generate a detail report for Pharmacy Claims using the Provider Electronic Solutions software. This detail report contains all the fields on the NCPDP Pharmacy Form.

To generate an NCPDP Pharmacy Detail Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **NCPDP Pharmacy** option from the **Detail Forms** drop down menu.

The NCPDP Pharmacy Detail Report screen is displayed.

Step 2. Click OK to include all the Pharmacy Claims in the detail report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

The detailed report is generated and displayed on your screen.

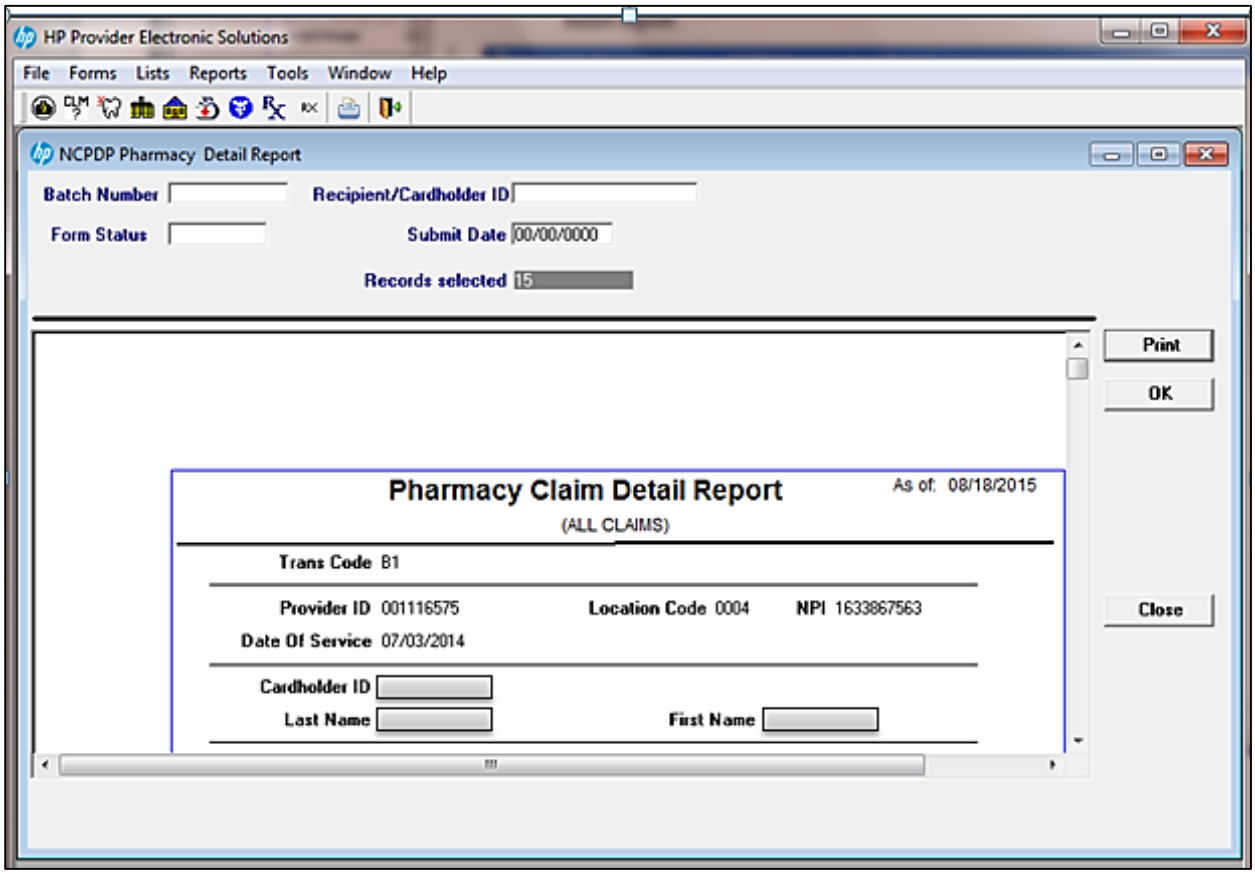
To limit the type of Pharmacy Claims in the detail report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to Pharmacy Claims in a specific batch. Enter the appropriate batch ID number in this field. You can locate the batch numbers under the Resubmission option of the View Communication Log menu.
Recipient/ Client ID	Limits the summary report to Pharmacy Claims for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Pharmacy Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Pharmacy Claims transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The detailed report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the NCPDP Pharmacy Detail Report.

Step 7. Click Close to exit the NCPDP Pharmacy Detail Report screen.

11.14 NCPDP Pharmacy Summary Report

You can generate a summary report for the Pharmacy Claim using the Provider Electronic Solutions software. This summary report contains all the fields on the NCPDP Pharmacy form.

To generate an NCPDP Pharmacy Summary Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **NCPDP Pharmacy** Option from the **Summary Forms** drop down menu.

The NCPDP Pharmacy Summary Report screen is displayed.

Step 2. Click OK to include all the Pharmacy Claims in the summary report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A summary report is generated and displayed on your screen.

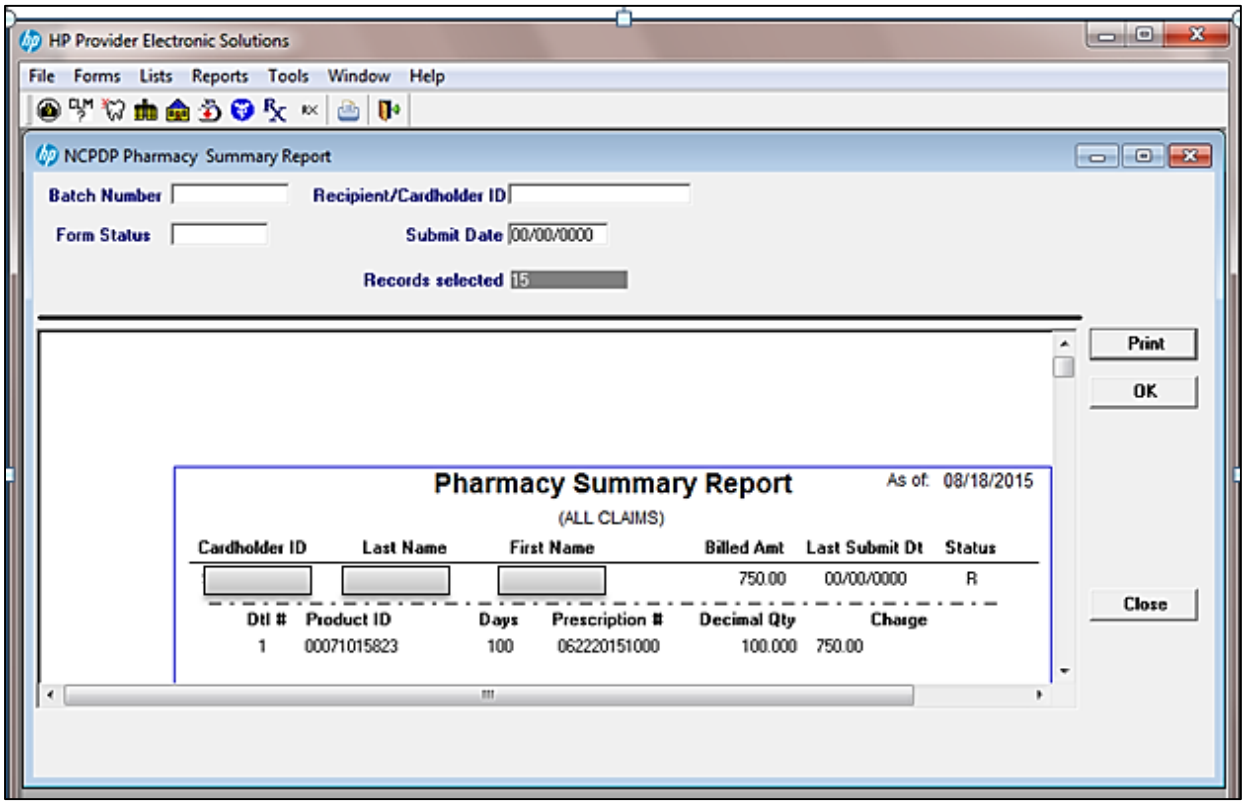
To limit the type of Pharmacy Claims in the summary report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to Pharmacy Claims in a specific batch. Enter the appropriate Batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient ID	Limits the summary report to Pharmacy Claims for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Pharmacy Claims with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Pharmacy Claims transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The summary report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the NCPDP Pharmacy Summary Report.

Step 7. Click Close to exit the NCPDP Pharmacy Summary Report screen.

11.15 NCPDP Pharmacy Eligibility Detail Report

You can generate a detail report for the NCPDP Pharmacy Eligibility Inquiries using the Provider Electronic Solutions software. This detail report contains all the fields on the NCPDP Pharmacy Eligibility Form.

To generate an NCPDP Pharmacy Eligibility Detail Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **NCPDP Pharmacy Eligibility** option from the **Detail Forms** drop down menu.

The NCPDP Pharmacy Eligibility Detail Report screen is displayed.

Step 2. Click OK to include all the Pharmacy Eligibility Inquires in the detail report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A detailed report is generated and displayed on your screen.

To limit the type of Pharmacy Eligibility Inquires in the detail report, enter the appropriate report criteria into one or more of the following fields:

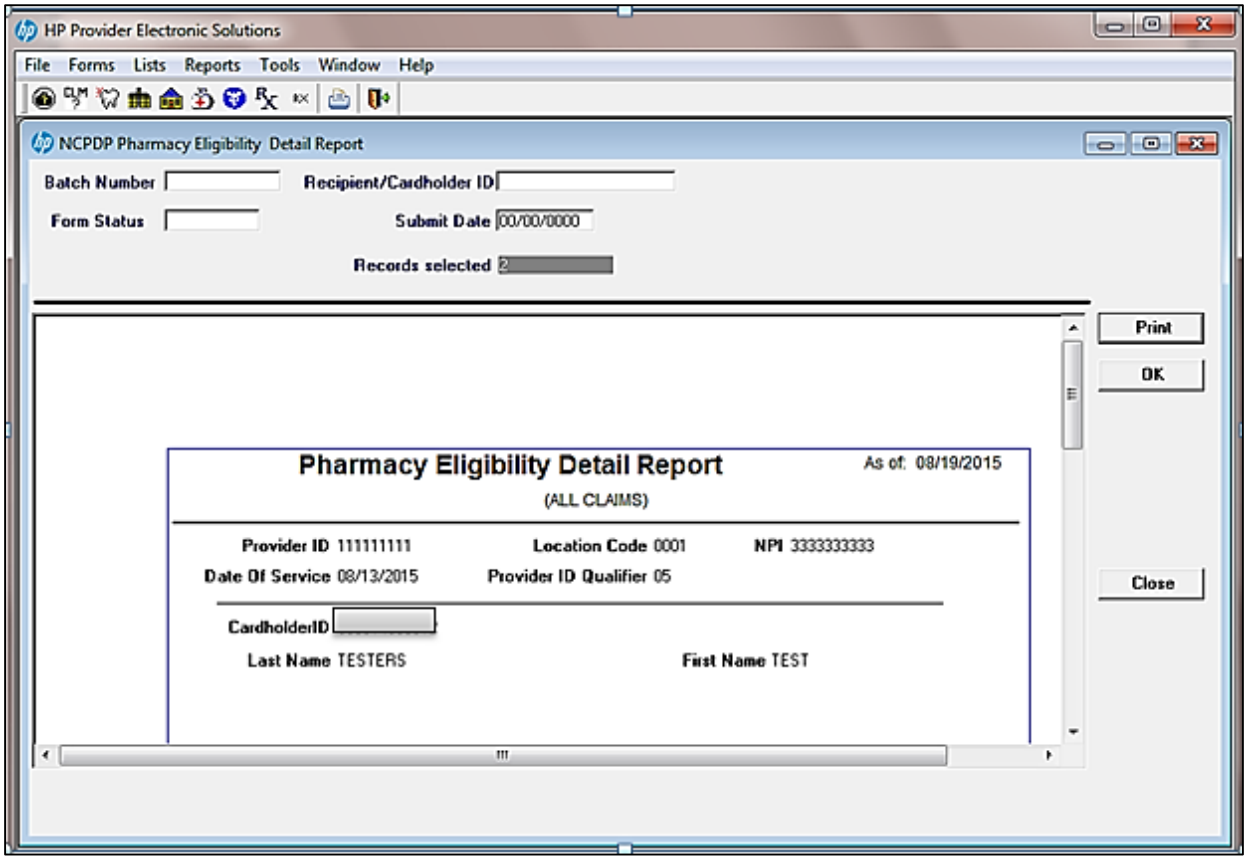
Batch Number	Limits the summary report to Pharmacy Eligibility Inquires in a specific batch. Enter the appropriate batch ID number in this field. You can locate the batch numbers under the Resubmission option of the View Communication Log menu.
Recipient ID	Limits the summary report to Pharmacy Eligibility Inquires for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Pharmacy Eligibility Inquires with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Pharmacy Eligibility Inquires transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click

.

The detailed report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the NCPDP Pharmacy Eligibility Detail Report.

Step 7. Click Close to exit the NCPDP Pharmacy Eligibility Detail Report screen.

11.16 NCPDP Pharmacy Eligibility Summary Report

You can generate a summary report for the NCPDP Pharmacy Eligibility Inquiries using the Provider Electronic Solutions software. This summary report contains only the key fields on the NCPDP Pharmacy Eligibility Form.

To generate an NCPDP Pharmacy Eligibility Summary Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **NCPDP Pharmacy Eligibility** Option from the **Summary Forms** drop down menu.

The NCPDP Pharmacy Eligibility Summary Report screen is displayed.

Step 2. Click OK to include all the Pharmacy Eligibility Inquires in the summary report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A detail report is generated and displayed on your screen.

To limit the type of Pharmacy Eligibility Inquires in the summary report, enter the appropriate report criteria into one or more of the following fields:

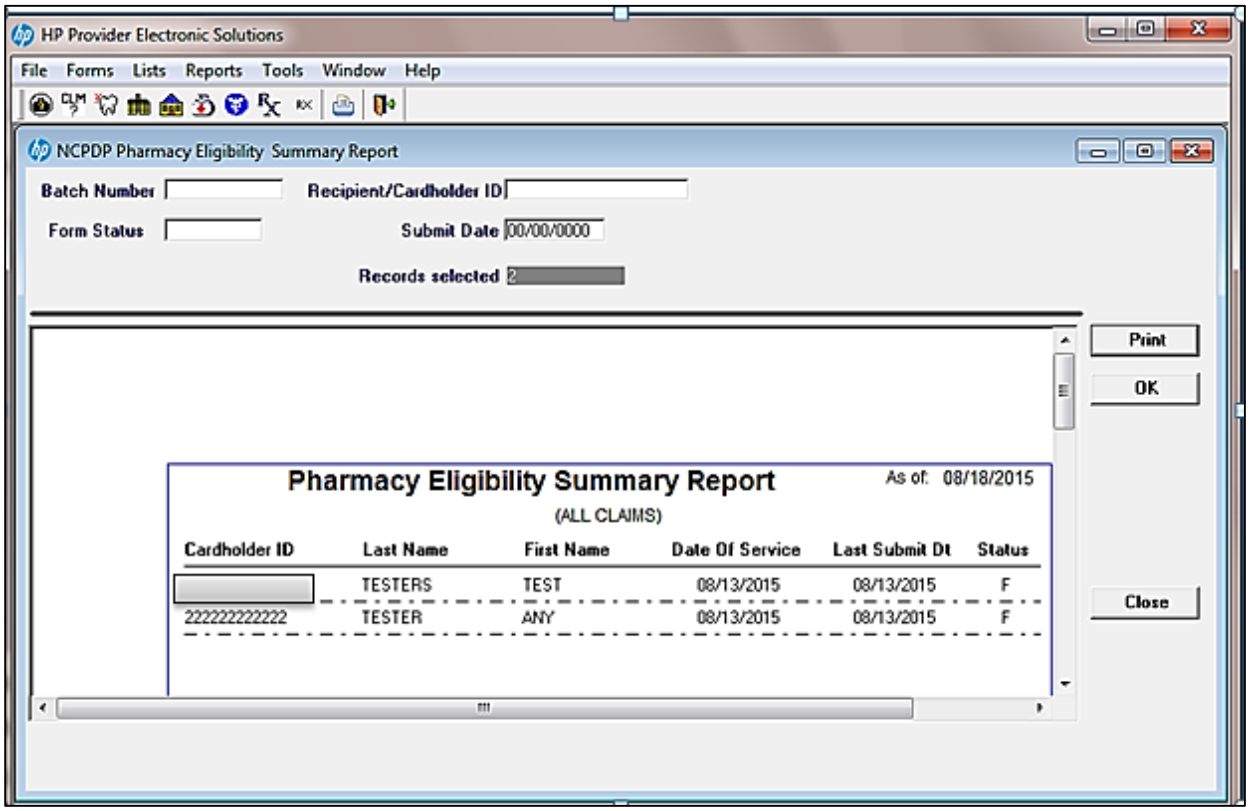
Batch Number	Limits the summary report to Pharmacy Eligibility Inquires in a specific batch. Enter the appropriate Batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient ID	Limits the summary report to Pharmacy Eligibility Inquires for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Pharmacy Eligibility Inquires with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Pharmacy Eligibility Inquires transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click

.

The summary report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the NCPDP Pharmacy Eligibility Summary Report.

Step 7. Click Close to exit the NCPDP Pharmacy Eligibility Summary Report screen.

11.17 NCPDP Pharmacy Reversal Detail Report

You can generate a detail report for the NCPDP Pharmacy Reversal Requests using the Provider Electronic Solutions software. This detail report contains all the fields on the NCPDP Pharmacy Reversal Form.

To generate an NCPDP Pharmacy Reversal Detail Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, selecting the **NCPDP Pharmacy Reversal** option from the **Detail Forms** drop down menu.

The NCPDP Pharmacy Reversal Detail Report screen is displayed.

Step 2. Click OK to include all the Pharmacy Reversal Requests in the detail report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected

A detail report is generated and displayed on your screen.

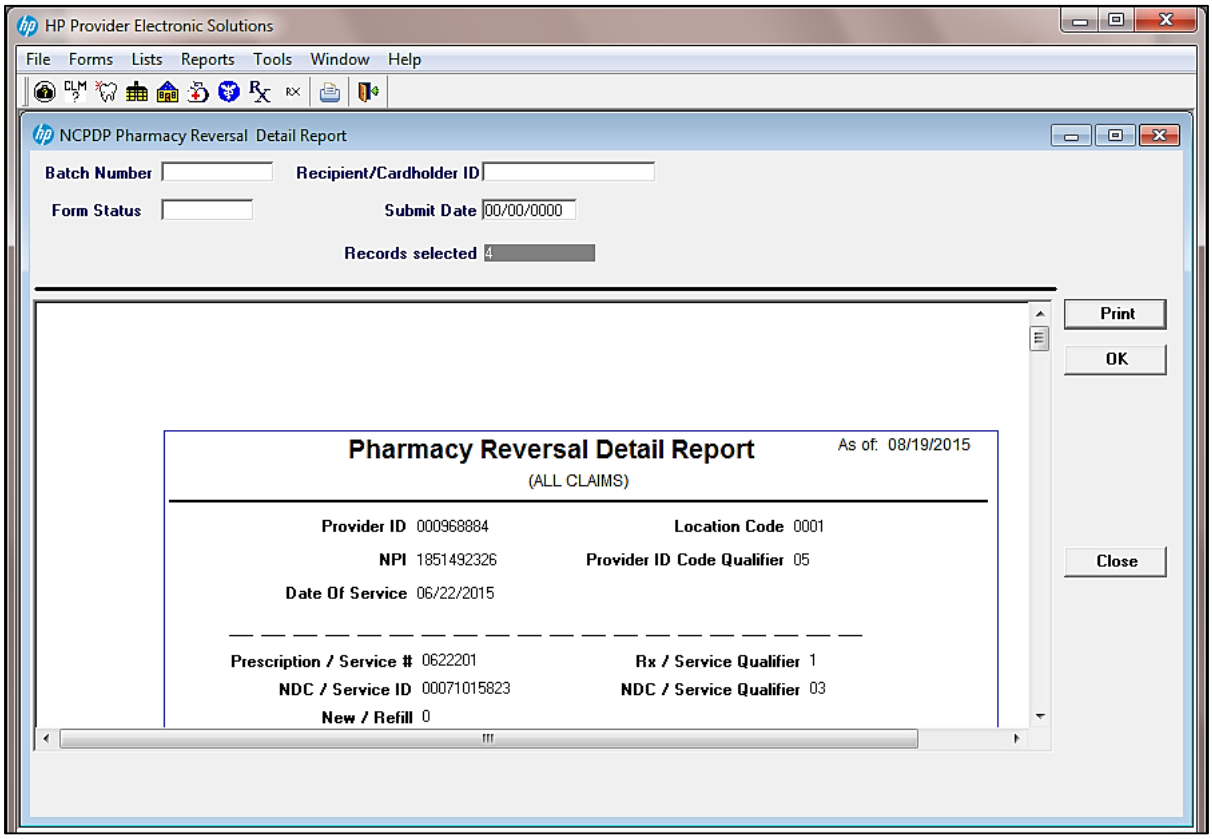
To limit the type of Pharmacy Reversal Requests in the detail report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the detail report to Pharmacy Reversal Requests in a specific batch. Enter the appropriate batch ID number in this field. You can locate the Batch Numbers under the Resubmission option of the View Communication Log menu.
Recipient ID	Limits the detail report to Pharmacy Reversal Requests for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the detail report to Pharmacy Reversal Requests with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the detail report to Pharmacy Reversal Requests transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The detailed report is generated and displayed on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the NCPDP Pharmacy Reversal Detail Report.

Step 7. Click Close to exit the NCPDP Pharmacy Reversal Detail Report screen.

11.18 NCPDP Pharmacy Reversal Summary Report

You can generate a summary report for NCPDP Pharmacy Reversal Requests using the Provider Electronic Solutions software. This summary report contains all the fields on the NCPDP Pharmacy Reversal Form.

To generate an NCPDP Pharmacy Reversal Summary Report, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **NCPDP Pharmacy Reversal** option from the **Summary Forms** drop down menu.

The NCPDP Pharmacy Reversal Summary Report screen is displayed.

Step 2. Click OK to include all the Pharmacy Reversal Requests in the summary report.

Step 3. Click OK when prompted by the box that advises you that all records will be selected.

A summary report is generated and displayed on your screen.

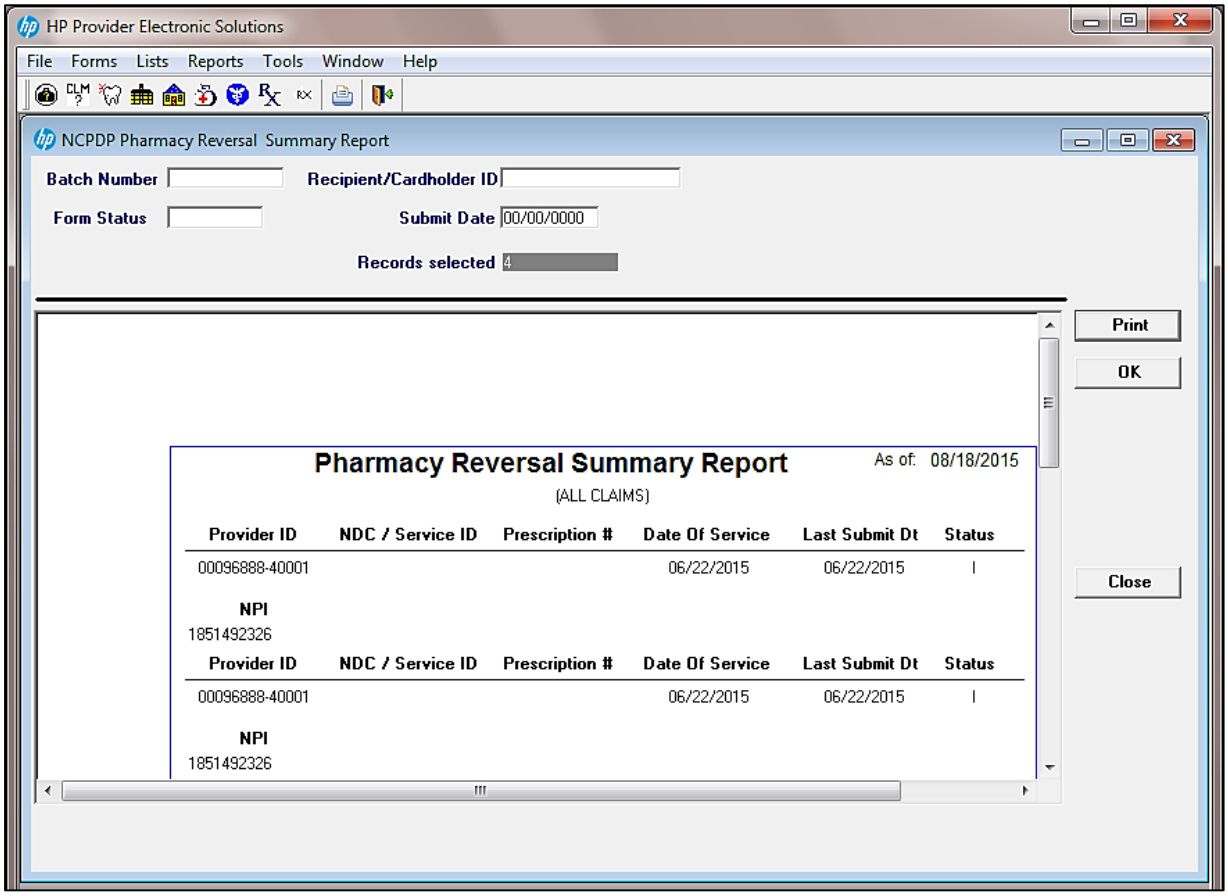
To limit the type of Pharmacy Reversal Requests in the summary report, enter the appropriate report criteria into one or more of the following fields:

Batch Number	Limits the summary report to Pharmacy Reversal Requests in a specific batch. Enter the appropriate batch ID number in this field. You can locate the batch numbers under the Resubmission option of the View Communication Log menu.
Recipient ID	Limits the summary report to Pharmacy Reversal Requests for the specified recipient. Enter the appropriate recipient ID in this field.
Form Status	Limits the summary report to Pharmacy Reversal Requests with the specified form status. Select the appropriate form status from this drop down list.
Submit Date	Limits the summary report to Pharmacy Reversal Requests transmitted on the specified date. Enter the appropriate date in this field.

Step 4. After you enter the report criteria, click OK.

The software generates the summary report and displays it on your screen.

Step 5. Use the scroll bars (located on the right side and bottom of the screen) to view the entire report.



Step 6. Click Print to print the NCPDP Pharmacy Reversal Summary Report.

Step 7. Click Close to exit the NCPDP Pharmacy Reversal Summary Report screen.

11.19 Master List of Selections for a Reference List

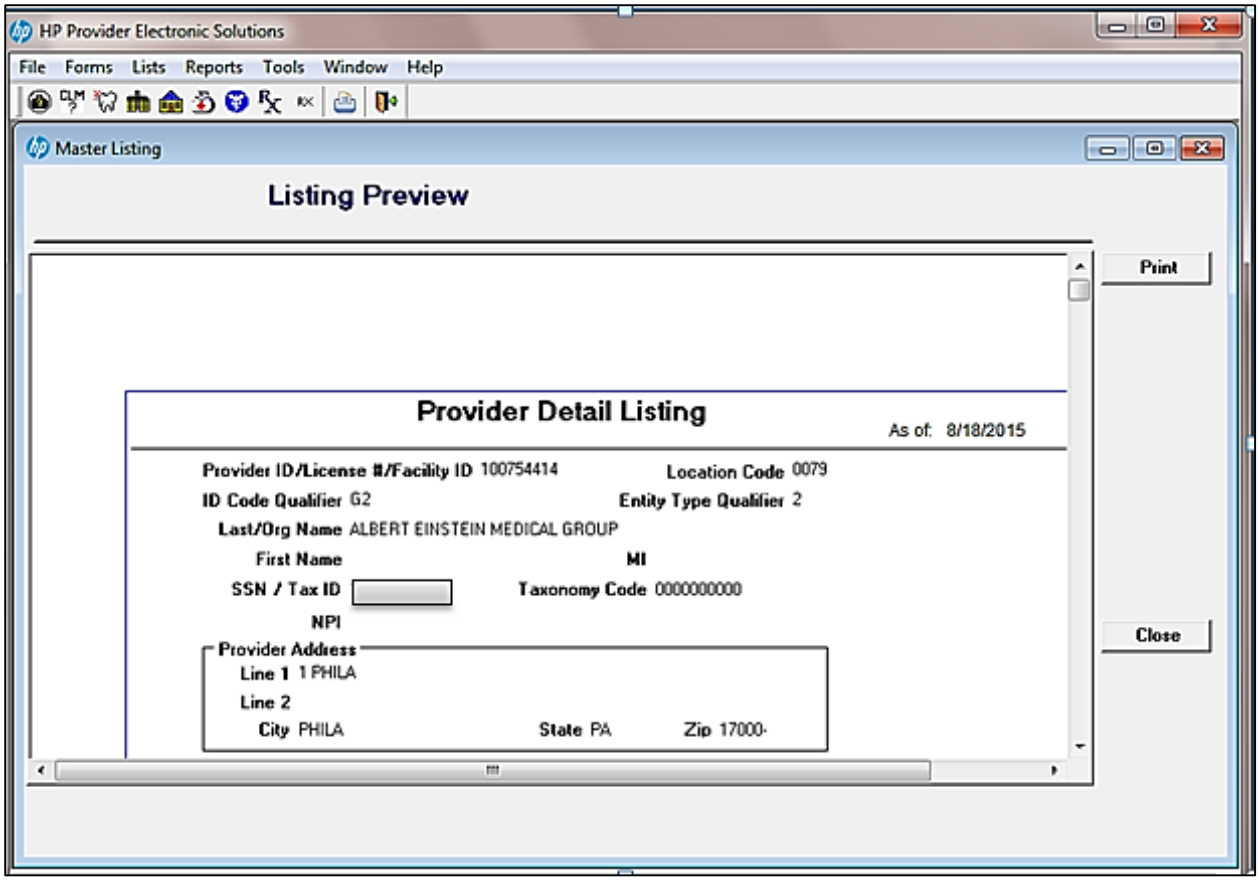
In addition to generating detail and summary reports, the Reports menu lets you access a Reference list, and view and print a Master list of the selections for that Reference list.

To generate a master list of selections for a Reference list, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the reference list for which you would like to view selections from the **Reports** drop down menu.

The Master Listing screen is displayed. It lists each selection of the reference list.

Step 2. Use the scroll bars (located on the right side and bottom of the Master Listing screen) to view all the selections for the reference list.



Step 3. Click **Print** to print the master listing.

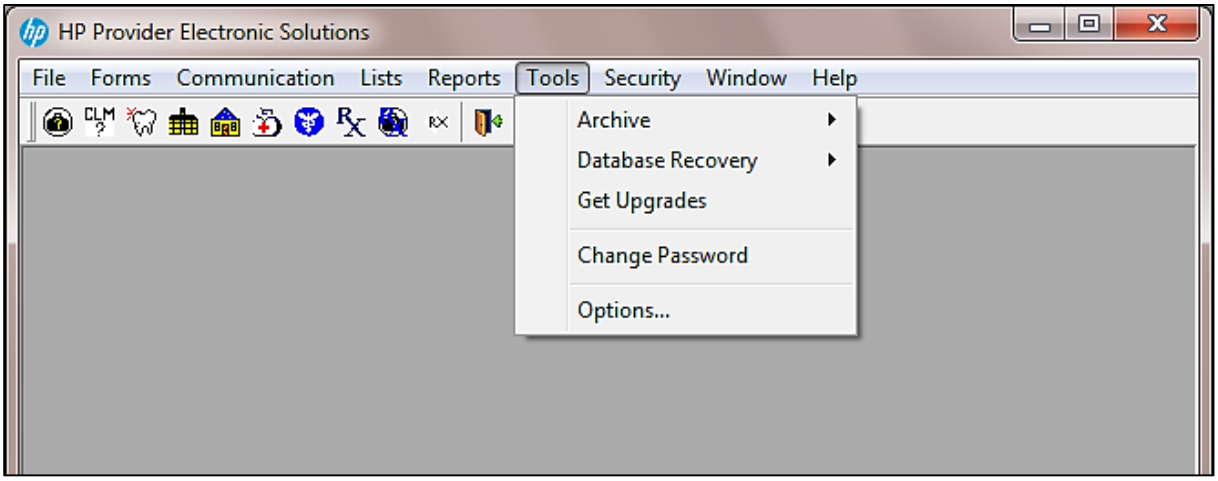
Step 4. Click **Close** to exit the Master Listing screen.

12 Using the Tool Functions

The Provider Electronic Solutions software provides several tool functions. These functions include the following:

- Archive files
- Database recovery
- Get software upgrades
- Change password
- Change communication options

You can access these functions from the **Tools** drop down menu on the main screen of the Provider Electronic Solutions software.

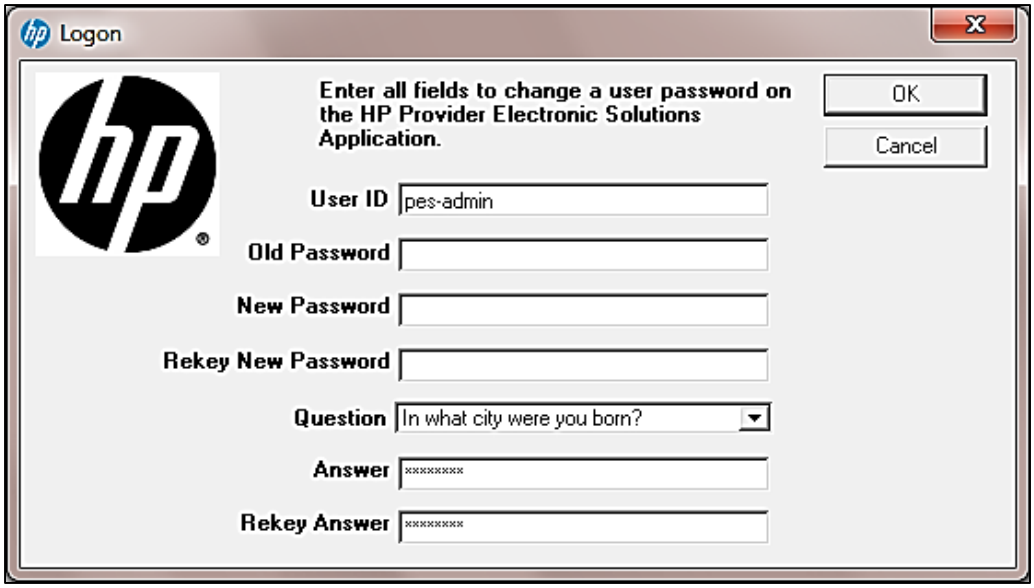


12.1 Change Your Password

To change your Provider Electronic Solutions software password, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **Change Password** option from the **Tools** drop down menu.

The Logon screen is displayed.



Step 2. Enter your old password in the **Old Password** field.

Step 3. Enter your new password in the **New Password** field.

Step 4. Re-enter your new password in the **Rekey New Password** field.

Step 5. Select a hint question from the **Question** field drop down list.

Step 6. Enter the answer to your hint question in the **Answer** field.

Step 7. Re-enter your answer to the hint question in the **Rekey Answer** field.

Step 8. Click OK to save your new password.

12.2 Compact the Database

You can compact your database to make the database files smaller and better organized. Whenever you delete a form, empty space is created in the database where that form existed. Compacting the database releases all empty space and makes it available again.

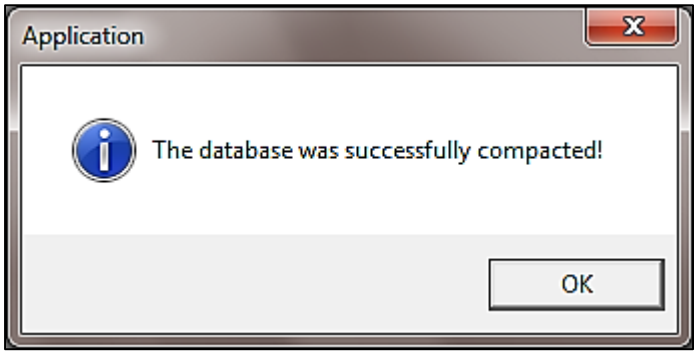
Note: You may want to compact your database if it is running slowly, or after archiving a number of claims.

To compact your database, perform the following steps:

Step 1. From the main menu of the Provider Electronic Solutions software, select the **Compact** option from the **Database Recovery** drop down menu.

A "**Compacting Database"** message is displayed while the database is being compacted.

Step 2. After the database is successfully compacted, the Application box is displayed with a message that indicates if the action was successful.



Step 3. Click OK to clear the message from your screen.

12.3 Repair the Database

You should repair your database whenever you have trouble accessing your data. The repair procedure tries to validate all system tables and all indexes.

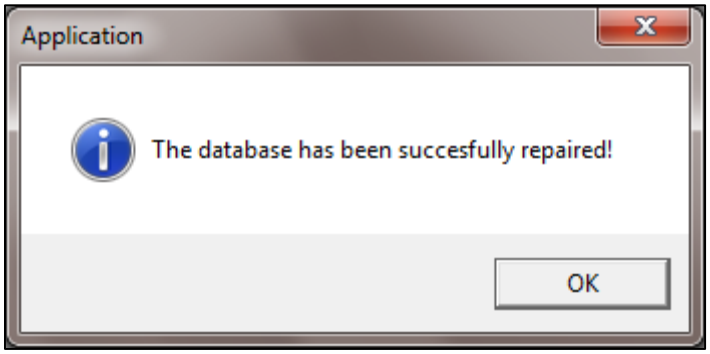
Note: You should compact your database after you use the repair procedure.

To repair your database, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **Repair** option from the **Database Recovery** drop down menu.

The message "**Repairing Database"** is displayed while the database is being repaired.

Step 2. After the database has been successfully repaired, this Application box is displayed with a message that indicates if the action was successful.



Step 3. Click OK to clear the message from your screen.

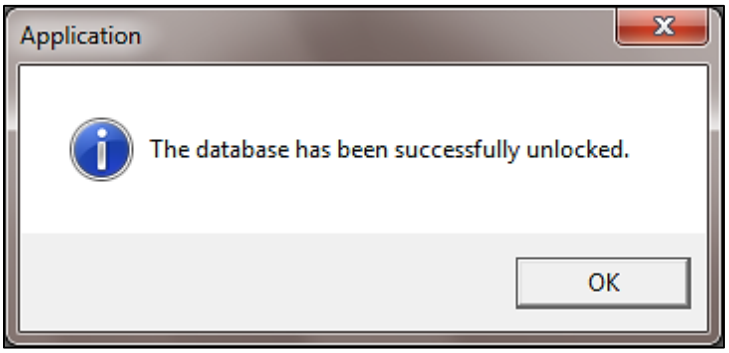
12.4 Unlock Your Database

You should unlock your database whenever system errors cause your database to lock.

To unlock your database perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **Unlock** option from the **Database Recovery** drop down menu.

Step 2. After the database has successfully unlocked, this Application box is displayed with a message that indicates if the action was successful.



Step 3. Click **OK** to clear the message from your screen.

Note: If when submitting claims using the Provider Electronic Solutions (PES) software you receive this error:

Complete the following steps to resolve this issue:

First step: Select the Tools/Database Recovery/Unlock - to unlock the claims. Go to update/create the claims.

If the step above does not resolve this issue:

Go to your local drive: c:\papromise folder
Look for the database with the extension "**panewecs.ldb**" and delete it (Do **not** delete the one with the extension .**mdb**, "panewecs.mdb").

12.5 Get Upgrades

You can go to the website to get the upgrades. The website is http://promise.dpw.state.pa.us/ePROM/_ProviderSoftware/softwareDownloadMain.asp

Under Billing Information double click on the Provider Electronic Solutions Software and follow the instructions for the upgrade.

When using the Web Server download the upgrades follow the steps below to upgrade using the software. You should only access this feature if you are notified that an upgrade to the Provider Electronic Solutions software is available.

To download an upgrade from the Web Server perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the Get Upgrades option.

Step 2. The software uses the Web Server to download any applicable upgrades.

Step 3. After downloading the upgrade, you need to access the upgrade shortcut in the Provider Electronic Solutions area of your Windows Start Menu.

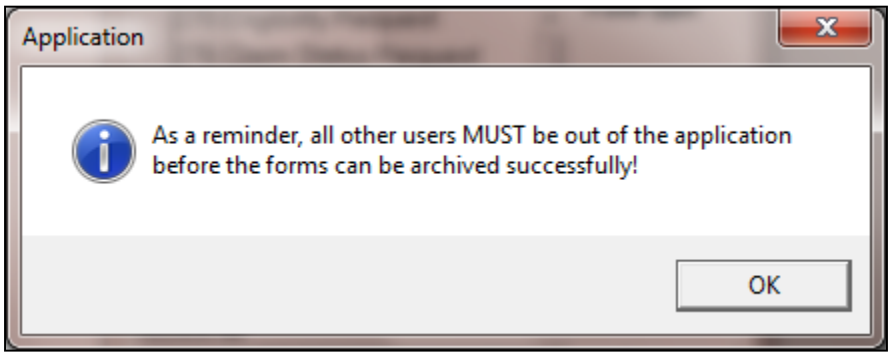
12.6 Create Archive

You should archive your database to keep the number of claims (for a particular form) manageable and to maintain historical records of the forms you have entered. It is also a good practice to archive your claims on a regular basis to protect them in case of a system failure.

To archive your database perform the following steps:

Step 1. From the main menu of the Provider Electronic Solutions software, select the **Create** option from the **Archive** drop down menu.

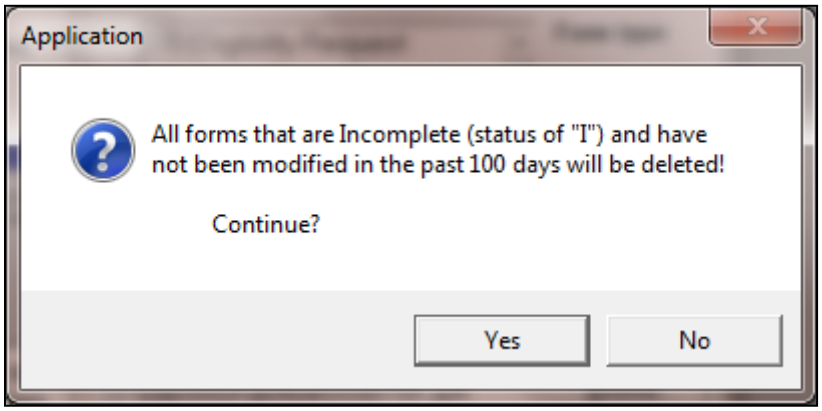
Step 2. The following message is displayed.


Application
As a reminder, all other users MUST be out of the application before the forms can be archived successfully!
OK

Note: Make sure all other users are logged off the system and all claims are **not** in a "Ready" status

Step 3. Click OK to clear the message from your screen. (This is only necessary if your system is shared across a network).

Step 4. The message below is then displayed:


Application
All forms that are Incomplete (status of "I") and have not been modified in the past 100 days will be deleted!
Continue?
Yes
No

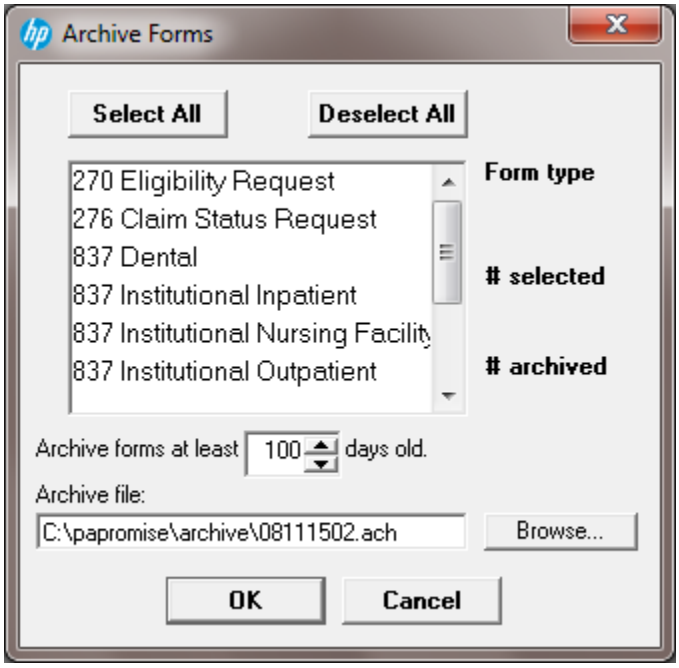
Note: All forms with an "**I**" status (Incomplete) that have not been modified in the past 30 days are deleted when you archive your database.

Step 5. Click No to cancel the archive procedure

or

Click Yes to continue with the archive procedure.

This Archive Forms screen is displayed.



Step 6. Select a form to use for the archive procedure,

or

Click Select All to select all the forms for the archive procedure,

or

Click Deselect All to deselect all the selected forms.

Step 7. Select the maximum age, in the number of days, for forms to be archived. The default value is 100 days (indicates that all claims older than 100 days will be archived).

Step 8. Enter the location of the archive file in the **Archive file** field.

You can place the compressed archive file on a diskette or leave it on your hard drive.

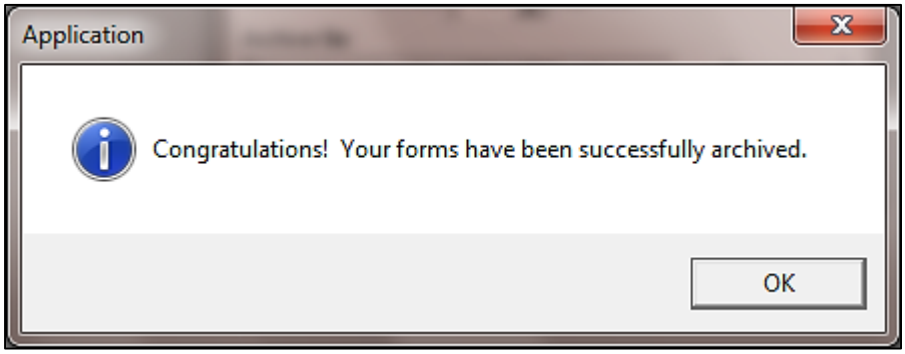
Step 9. Click Browse... to select a different directory for the archive file, if desired.

Step 10. Click Cancel to cancel the archive procedure,

or

Click OK to continue with the archive procedure.

Step 11. After the database has been successfully archived, the following message is displayed:



Step 12. Click OK to clear the message from your screen.

12.7 Restore Archive

You can restore forms from archive files to your database. Forms that have been archived and then restored have a status of "**A.**" You cannot change these forms; however, you can view them to confirm information, print them in a report, and copy them to create a new form.

To restore forms from an archive file perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select the **Restore** option from the **Archive** drop down menu.

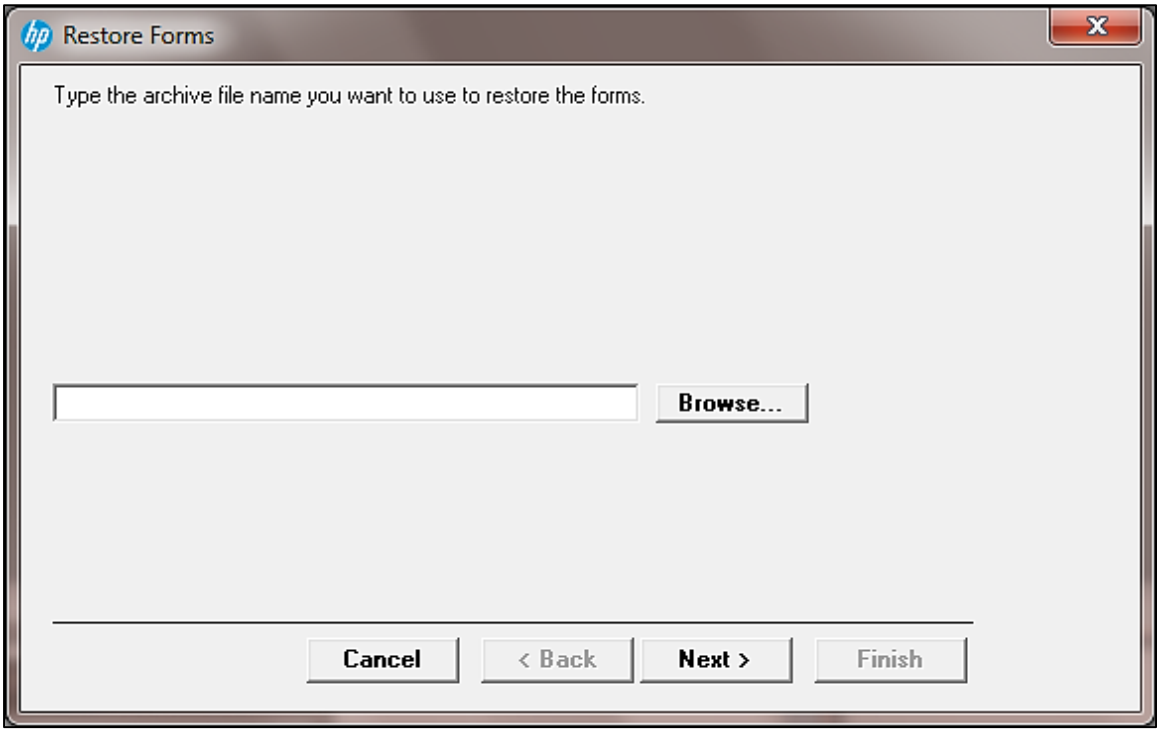
The Restore Forms screen is displayed.

Step 2. Enter the **name** and **location** of the archive file in the data entry field,

or

Click Browse... and select the location for the archive file.

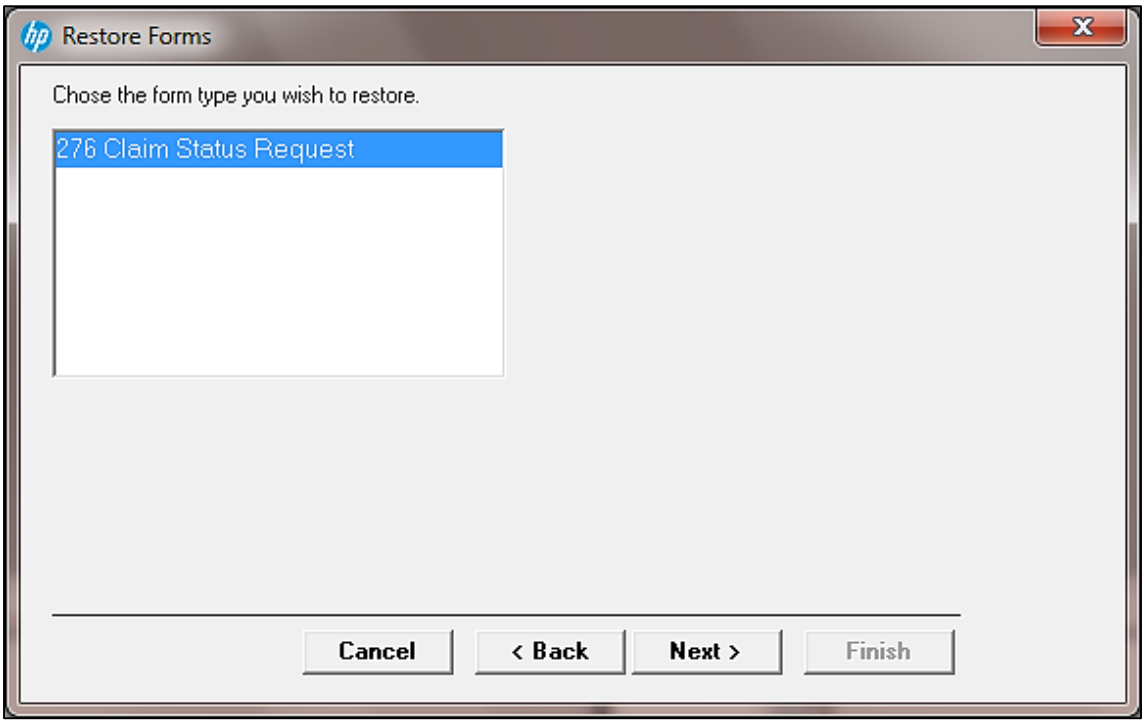
Note: Archive files have an extension of *.ach



Step 3. Click **Next >** after you select the archive file.

A list of all the form types is displayed.

Step 4. Select the form type you want to restore, and then click **Next >**.

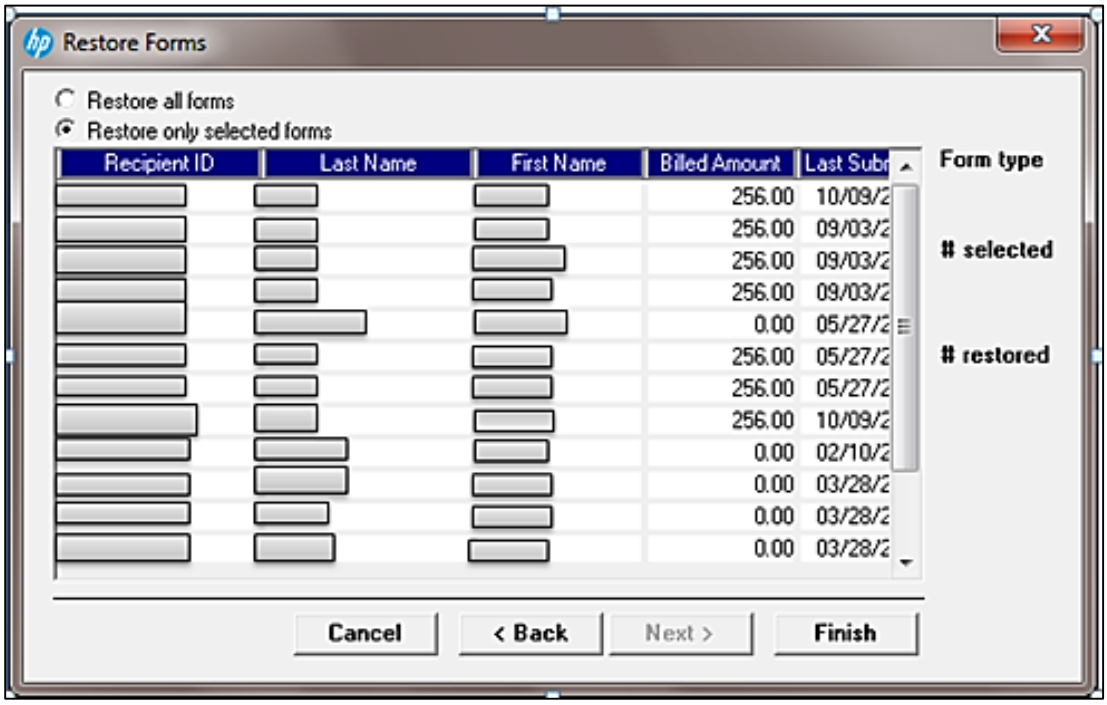


Step 5. Select the **Restore all forms** radio button to restore all the forms on the list,

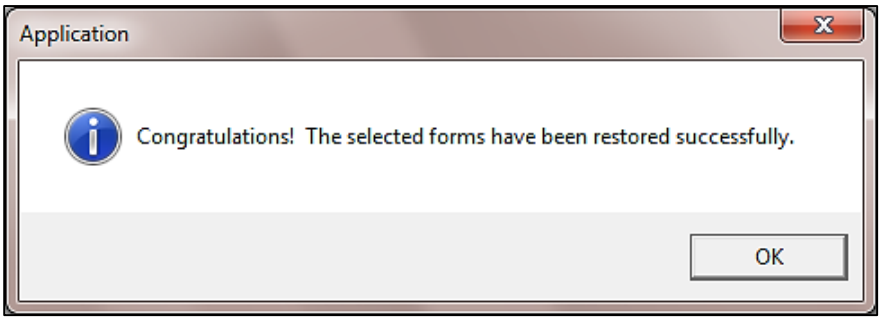
or

Select the Restore only selected forms radio button to restore only selected forms, and then click on an item to select it.

Step 6. Click **Finish** after you have selected the items that you want to restore.



Step 7. After the selected forms are successfully restored, the following message is displayed.



Step 8. Click **OK** to clear the message from your screen.

The item(s) that you have restored is (are) placed back into the corresponding Form option. You can access an item when you select the Forms menu or a Form short cut, which are located on the main screen.

12.8 Modify Options Settings

Use the Options form to update your system's logon, software settings, and transmission information. The Options form is divided into six screens. Each screen contains the following data:

Modem	System modem information.
Web	System Web information.
Batch	System batch information.
Interactive	System interactive information.
Carrier	System carrier information.
Payer/Processor	System payer/processor information.
Retention	System retention information.

To make changes to the Options Form, perform the following steps:

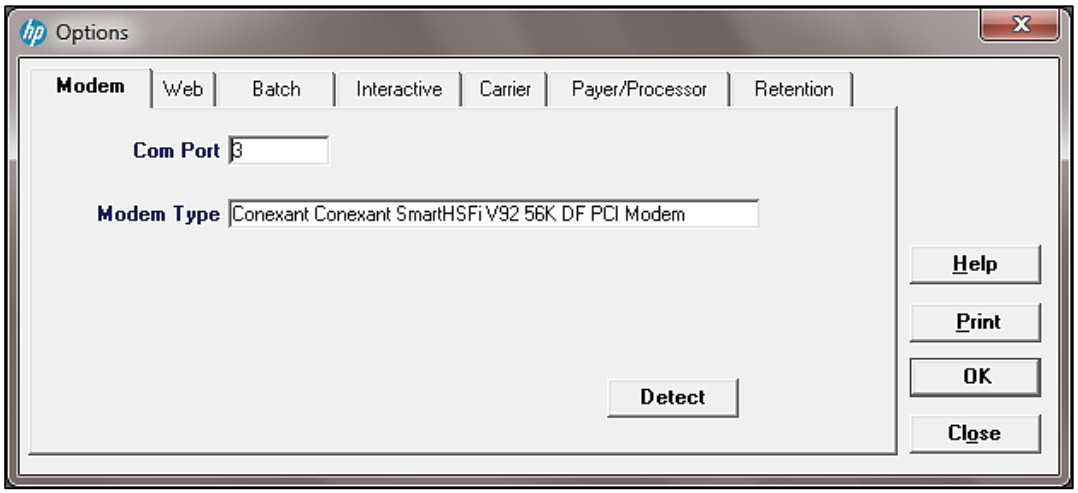
Step 1. From the main screen of the Provider Electronic Solutions software, select **Options** from the **Tools** drop down menu.

The Options form appears with the Modem screen displayed.

Step 2. Select the screen that contains the fields you want to change.

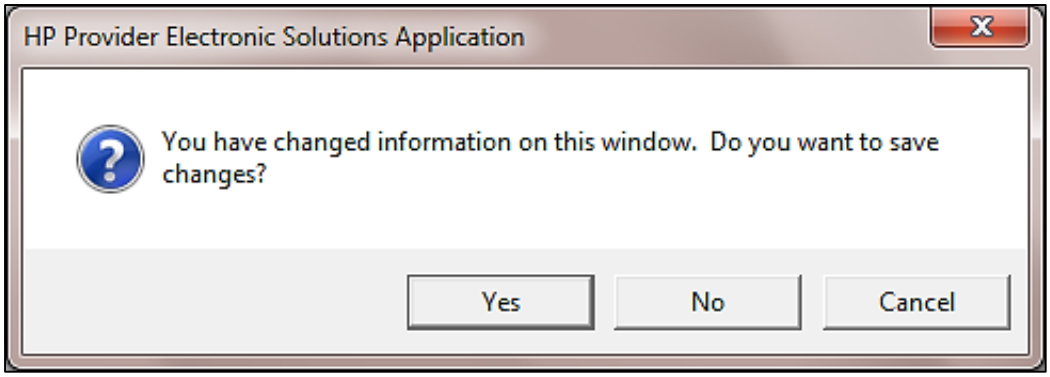
Step 3. Make the appropriate changes and click OK to save the changes.

For additional information about completing the Options screens, see section 5, *Complete Transmission Options* of this manual.



Step 4. Click Close to exit the Options box.

Step 5. If you have made any changes and NOT clicked OK, the following screen is displayed:


HP Provider Electronic Solutions Application
You have changed information on this window. Do you want to save changes?
Yes
No
Cancel

Click Yes to save your changes.

or

Click No to delete your changes.

or

Click Cancel to return to the Options box.

13 Security Functions

The Provider Electronic Solutions software provides a security function that allows an administrator to do the following:

- Create Multiple User IDs for the software.
- Assign Passwords to the User IDs.
- Assign Authorization or Access to users.
- Monitor User ID access to the system.

It is strongly recommended that all users add at least one additional Administrator level ID and password to the software.

Adding an administrator level ID ensures that, if there is a problem with accessing the software, a known User ID and password value can be used to access the system.

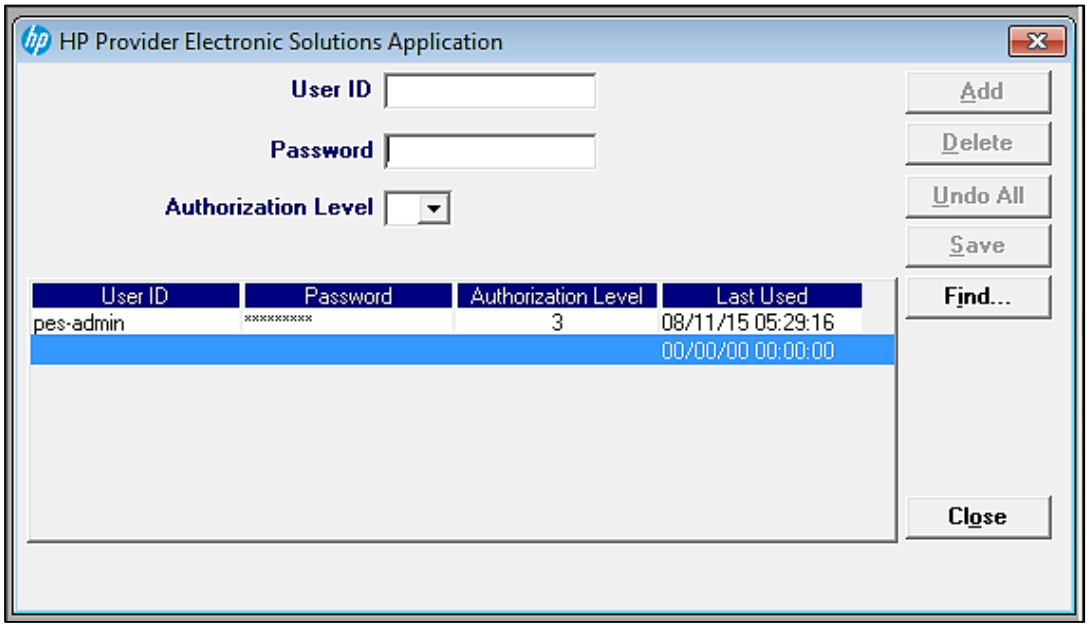
> **Note:** The default User ID – pes-admin, and default password hp-pes, should only be used for the initial set up of the program and for technical support, if needed.

13.1 Add Additional Users

To add another user to the Provider Electronic Solutions software, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select **Security Maintenance** from the Security Menu.

Step 2. The Security Maintenance screen is displayed.



Step 3. Enter a user ID in the **User ID** field.

User IDs must be longer than five characters and are case sensitive.

Step 4. Enter the user's password in the **Password** field.

Passwords must be longer than five characters long, and are case sensitive.

Step 5. Select the Authorization Level you wish to assign to the user from the **Authorization Level** drop down box. Each level allows the user the type of access described in the table below.

User	Allows access to enter the system and send claims, but cannot make changes to software.
Administrator	Allows complete access to the software, including all settings.

Step 6. Click Save to save your added User ID.

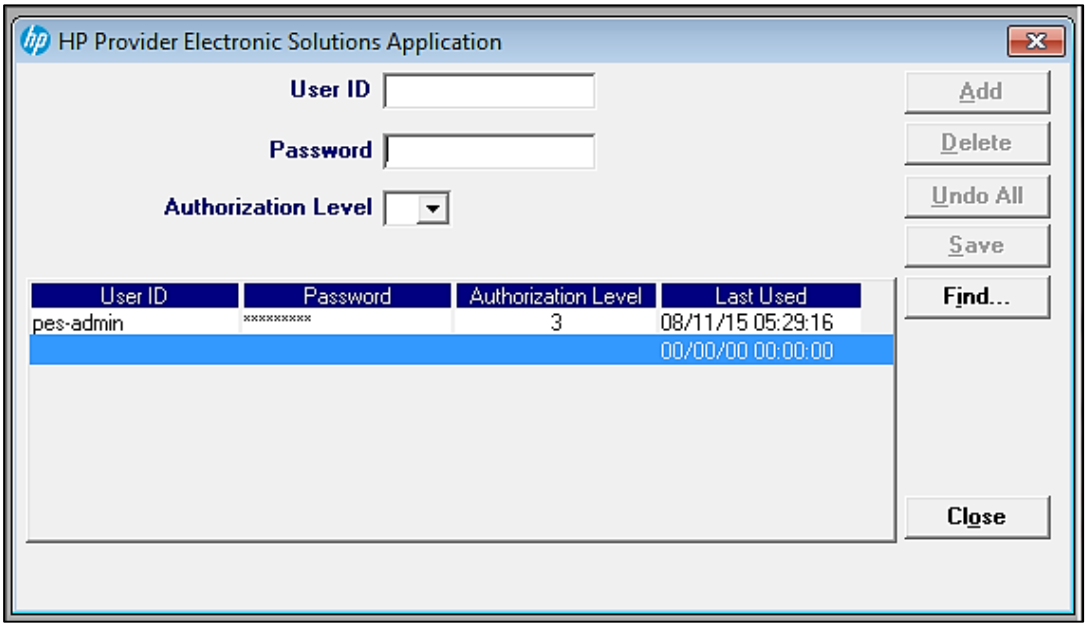
Step 7. Click Add to add a new User ID.

13.2 Edit Existing Users

To edit Security Information in the Provider Electronic Solutions software, perform the following steps:

Step 1. From the main screen of the Provider Electronic Solutions software, select **Security Maintenance** from the Security Menu.

The Security Maintenance screen is displayed.



Step 2. Select a user ID in the **User ID** field.

Step 3. Change the information you wish to change for that User ID.

Step 4. Click Save to save your updated User ID.

14 Contact Information

For additional information regarding the Provider Electronic Solutions software, or MA billing and policy questions, please contact the phone numbers below:

Technical Questions with the Provider Electronic Solutions software	
HP Enterprise Services Provider Assistance Center	1-800-248-2152 or 717-975-4100
MA Billing or Policy Questions	
Provider Inquiry – Practitioner Unit	1-800-537-8862
Provider Inquiry – Pharmacy and Ancillary Unit	1-800-537-8862
Provider Inquiry – Inpatient Unit	1-800-537-8862
Provider Inquiry – Office of Long Term Living Unit	1-800-932-0939
Behavioral Health Provider Hotline	1-800-433-4459
Internet Resources	
Department of Human Services Web site	http://www.dhs.state.pa.us/
PROMISe™ Web site	https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider
E-mail Resources	
HP Enterprise Services Provider Assistance Center	papac1@hp.com
HIPAA Information	pahipaa@hp.com
PROMISe™ Information	promise@state.pa.us
Contact Information/Help for MA Providers	http://www.dhs.state.pa.us/provider/index.htm

15 Appendix A - Frequently Asked Questions

837 Institutional Long Term Care Forms

How do I use the Provider Electronic Solutions software to bill Non Covered Medicare Services?

As a **temporary** solution to address the issue surrounding non covered Medicare Charges (MAMIS Attachment Type Codes 40-45), you would complete the PES 837 LTC transaction as follows: Go to Header 3 and set the Crossover Indicator to Yes. Go to the Crossover screen and fill out all of the appropriate Medicare Information. Indicate a Medicare Denial by using the Reason code 50, use the resident's date of admission as the Paid Date, and use 11111111111111 as the Medicare ICN number.

16 Appendix B – Eligibility Response Code Tables

16.1 Eligibility or Benefit Information Codes*

The codes in the table below **may** be included in the Eligibility Benefit Response Information sections of the 271 Response.

1	Active Coverage
2	Active – Full Risk Capitation
3	Active – Services Capitated
4	Active – Services Capitated to Primary Care Physician
5	Active – Pending Investigation
6	Inactive
7	Inactive – Pending Eligibility Update
8	Inactive – Pending Investigation
A	Co-Insurance
B	Co-Payment
C	Deductible
CB	Coverage Basis
D	Benefit Description
E	Exclusions
F	Limitations
G	Out of Pocket (Stop Loss)
H	Unlimited
I	Non-Covered
J	Cost Containment
K	Reserve
L	Primary Care Provider
M	Pre-existing Condition
MC	Managed Care Coordinator
N	Services Restricted to the Following Provider
O	Not Deemed a Medical Necessity
P	Benefit Disclaimer
Q	Second Surgical Opinion Required
R	Other or Additional Payer
S	Prior Year(s) History
T	Card(s) Reported Lost/Stolen
U	Contact Following Entity for Eligibility or Benefit Information
V	Cannot Process
W	Other Source of Data
X	Health Care Facility
Y	Spend Down

16.2 Reject Reason Codes*

These codes are used when a rejection is sent back for a 270 Request, rather than a 271 Response.

Error Code	271 X12 Error Status Code Description	Why the Error Set
42	Unable to Respond at Current Time	A PROMISe™ error has occurred. Please try again.
43	Invalid/Missing Provider Identification	PROMISe™ provider number is not 13 digits long. Verify that you are using a valid 13-digit number and not an old 8-digit MA ID number. Also returned for Health Care providers who are not using their National Provider Identifier after May 23rd 2008.
50	Provider Ineligible for Inquiries	LIHEAP Providers are not eligible to enquire eligibility on MA recipients.
51	Provider Not on File	Provider number submitted is not a valid number. Verify the number submitted. If an NPI is submitted and zip code or taxonomy is sent, confirm that the zip code and/or the taxonomy matches with the providers registered NPI information.
52	Service Dates Not Within Provider Plan Enrollment	The inquiry made covers a range of dates and the provider is not eligible part or all of the period of eligibility being requested. PROMISe™ will still return eligibility for the period when the provider is eligible, however, you will not get eligibility for all the days requested. Verify that you are using a valid and open PROMISe™ provider number and service location for the inquiry.
55	Inappropriate Product/Service ID	Error only applies to inquiries that include a procedure code or NDC. The inquiry failed to find the procedure code or NDC submitted. Verify that you are using a valid procedure code or NDC.
57	Invalid/Missing Date(s) of Service	Range of dates of service submitted exceeds a 31-day period. Maximum number of days is 30.
58	Invalid/Missing Date-of-Birth	Date of birth is required when performing a name or SSN inquiry.
60	Date of Birth Follows Date(s) of Service	Date of service submitted is before the date of birth on the recipient's eligibility file.
61	Date of Death Precedes Date(s) of Service	Date of service submitted is after the date of death on the recipient's eligibility file.

Error Code	271 X12 Error Status Code Description	Why the Error Set
62	Date of Service not within Allowable Inquiry Period.	Date Of Service In past (more than 10 years) or future (greater than last day of the current month) For ePrescribing - Date Of Service cannot be in the past
		Social Security Number (SSN) submitted contains alpha characters or is not 9 digits. Verify the SSN you submitted.
69	Inconsistent with Patient's Age	Error only applies to inquiries that include a procedure code or NDC. The recipient is too young or too old for the procedure code or NDC submitted.
70	Inconsistent with Patient's Gender	Error only applies to inquiries that include a procedure code or NDC. The gender of recipient is not valid for the procedure code or NDC submitted.
71	Patient Birth Date Does Not Match That for the Patient on the Database	Error returned if DOB submitted does not match recipient DOB on file.
72	Invalid/Missing Subscriber/Insured ID	Recipient number submitted on the inquiry is invalid, is not numeric or 10 digits in length, or the card issue number is invalid. Verify that you submitted a valid 10-digit recipient number and the current card issue number. <OR> Under 5010 the Error 72 can be returned in situations where more than one recipient is found for the search criteria specified on the 270. Typically Name/DOB or SSN/Dob search. <OR> With CAQH/CORE an error 72 is now returned when the valid RID sent does not match any RID on CIS <OR> the RID sent is all ZERO's.
73	Invalid/Missing Subscriber/Insured Name	Missing First or Last Name.
75	Subscriber/Insured Not Found	Recipient was not found based on the information submitted. Verify the recipient information.
76	Duplicate Subscriber/Insured ID Number	Based on the information submitted, more than one recipient was found. Use another search criteria such as Recipient number and card issue number.

Error Code	271 X12 Error Status Code Description	Why the Error Set
79	Invalid Participant Identification	The Out-of-Network Provider ID submitted is not found. Verify you are using a valid 13-digit PROMISe™ out-of-network provider number. - OR- ePrescribing - At LP2100A level of the transaction, the DHS Tax ID is present, but it is not correct. Verify that you are submitting the valid tax ID for DHS.
IC	Invalid Card (Internal Only; Users see AAA 72)	The recipient's 2-digit card number supplied on the EVS request did not match the recipient's current active card number. Only appears in the PROMISE Online application. EVS users see a "72" returned for an invalid card.
NF	Recipient Not Found (Internal Only; Users see AAA 72)	The Recipient ID and Card/DOB were not found on file. EVS users see a "72" returned.
T4	Payer Name or Identifier Missing	The submitter did not identify DHS as the entity they are sending the 270 request to.

- HIPAA Compliant Codes — Currently, PROMISe™ does not use all of the codes that HIPAA permits.

16.3 Service Type Codes*

CODE DEFINITION

1 Medical Care

2 Surgical

3 Consultation

4 Diagnostic X-Ray

5 Diagnostic Lab

6 Radiation Therapy

7 Anesthesia

8 Surgical Assistance

9 Other Medical

10 Blood Charges

11 Used Durable Medical Equipment

12 Durable Medical Equipment Purchase

13 Ambulatory Service Center Facility
14 Renal Supplies in the Home
15 Alternate Method Dialysis
16 Chronic Renal Disease (CRD) Equipment
17 Pre-Admission Testing
18 Durable Medical Equipment Rental
19 Pneumonia Vaccine
20 Second Surgical Opinion
21 Third Surgical Opinion
22 Social Work
23 Diagnostic Dental
24 Periodontics
25 Restorative
26 Endodontics
27 Maxillofacial Prosthetics
28 Adjunctive Dental Services
30 Health Benefit Plan Coverage. If only a single category of inquiry can be supported, use this code.
32 Plan Waiting Period
33 Chiropractic
34 Chiropractic Office Visits
35 Dental Care
36 Dental Crowns
37 Dental Accident
38 Orthodontics
39 Prosthodontics
40 Oral Surgery
41 Routine (Preventive) Dental
42 Home Health Care
43 Home Health Prescriptions
44 Home Health Visits
45 Hospice

46 Respite Care
47 Hospital
48 Hospital - Inpatient
49 Hospital - Room and Board
50 Hospital - Outpatient
51 Hospital - Emergency Accident
52 Hospital - Emergency Medical
53 Hospital - Ambulatory Surgical
54 Long Term Care
55 Major Medical
56 Medically Related Transportation
57 Air Transportation
58 Cabulance
59 Licensed Ambulance
60 General Benefits
61 In-vitro Fertilization
62 MRI/CAT Scan
63 Donor Procedures
64 Acupuncture
65 Newborn Care
66 Pathology
67 Smoking Cessation
68 Well Baby Care
69 Maternity
70 Transplants
71 Audiology Exam
72 Inhalation Therapy
73 Diagnostic Medical
74 Private Duty Nursing
75 Prosthetic Device
76 Dialysis
77 Otological Exam

78 Chemotherapy
79 Allergy Testing
80 Immunizations
81 Routine Physical
82 Family Planning
83 Infertility
84 Abortion
85 AIDS
86 Emergency Services
87 Cancer
88 Pharmacy
89 Free Standing Prescription Drug
90 Mail Order Prescription Drug
91 Brand Name Prescription Drug
92 Generic Prescription Drug
93 Podiatry
94 Podiatry - Office Visits
95 Podiatry - Nursing Home Visits
96 Professional (Physician)
97 Anesthesiologist
98 Professional (Physician) Visit - Office
99 Professional (Physician) Visit - Inpatient
A0 Professional (Physician) Visit - Outpatient
A1 Professional (Physician) Visit - Nursing Home
A2 Professional (Physician) Visit - Skilled Nursing Facility
A3 Professional (Physician) Visit - Home
A4 Psychiatric
A5 Psychiatric - Room and Board
A6 Psychotherapy
A7 Psychiatric - Inpatient
A8 Psychiatric - Outpatient
A9 Rehabilitation

AA Rehabilitation - Room and Board
AB Rehabilitation - Inpatient
AC Rehabilitation - Outpatient
AD Occupational Therapy
AE Physical Medicine
AF Speech Therapy
AG Skilled Nursing Care
AH Skilled Nursing Care - Room and Board
AI Substance Abuse
AJ Alcoholism
AK Drug Addiction
AL Vision (Optometry)
AM Frames
AN Routine Exam; Use for Routine Vision Exam only.
AO Lenses
AQ Nonmedically Necessary Physical
AR Experimental Drug Therapy
B1 Burn Care
B2 Brand Name Prescription Drug - Formulary
B3 Brand Name Prescription Drug - Non-Formulary
BA Independent Medical Evaluation
BB Partial Hospitalization (Psychiatric)
BC Day Care (Psychiatric)
BD Cognitive Therapy
BE Massage Therapy
BF Pulmonary Rehabilitation
BG Cardiac Rehabilitation
BH Pediatric
BI Nursery
BJ Skin
BK Orthopedic
BL Cardiac

BM Lymphatic
BN Gastrointestinal
BP Endocrine
BQ Neurology
BR Eye
BS Invasive Procedures
BT Gynecological
BU Obstetrical
BV Obstetrical/Gynecological
BW Mail Order Prescription Drug: Brand Name
BX Mail Order Prescription Drug: Generic
BY Physician Visit - Office: Sick
BZ Physician Visit - Office: Well
C1 Coronary Care
CA Private Duty Nursing - Inpatient
CB Private Duty Nursing - Home
CC Surgical Benefits - Professional (Physician)
CD Surgical Benefits - Facility
CE Mental Health Provider - Inpatient
CF Mental Health Provider - Outpatient
CG Mental Health Facility - Inpatient
CH Mental Health Facility - Outpatient
CI Substance Abuse Facility - Inpatient
CJ Substance Abuse Facility - Outpatient
CK Screening X-ray
CL Screening laboratory
CM Mammogram, High Risk Patient
CN Mammogram, Low Risk Patient
CO Flu Vaccination
CP Eyewear and Eyewear Accessories
CQ Case Management
DG Dermatology

DM Durable Medical Equipment

DS Diabetic Supplies

GF Generic Prescription Drug - Formulary

GN Generic Prescription Drug - Non-Formulary

GY Allergy

IC Intensive Care

MH Mental Health

NI Neonatal Intensive Care

ON Oncology

PT Physical Therapy

PU Pulmonary

RN Renal

RT Residential Psychiatric Treatment

TC Transitional Care

TN Transitional Nursery Care

UC Urgent Care

17 Appendix C - Glossary of Terms

Acronym/ Word	Description
ACCESS ID Card	Medical Assistance plastic ID card issued to recipients.
Access Plus Program	Enhanced primary care case management and disease management program. Refer to Bulletin 99-06-11 for instructions.
CAO	County Assistance Office – these offices administer all DHS benefit programs at the local level.
CARC	Claim Adjustment Reason Codes
Carrier Code	Number assigned to a specific insurance company.
CCR	Consolidated Community Reporting for OMHSAS
CIS	Client Information System
CRN	Claim Reference Number
Diagnosis	Identity of a condition, cause, or disease.
DOB	Date of Birth
DOD	Date of Death
DOI	Department of Insurance
DOS	Date of Service
DHS	Department of Human Services – sometimes called the department.
Drop down list	Also known as a reference list.
EOMB	Explanation of Medical Benefits
ERA	Electronic Remittance Advice
EFT	Electronic Funds Transfer
HCSIS	Home and Community Services Information System
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification.
ICD-10-CM/PCS	International Classification of Diseases, 10th Revision, Clinical Modification.
ICN	Internal Control Number – unique claim number that distinguishes claims within PROMISe™ and appears on a Remittance Advice statement.
PROMISe™ Legacy Numbers	Pennsylvania Medical Assistance Legacy Numbers – Master Provider Index (MPI) number – a 13 digit number that consist of the 9 digit provider ID and a 4 digit location number.
MA	Medical Assistance
MA ID	Medical Assistance Identification number
MCO	Managed Care Organization
MAMIS	Medical Assistance Management Information System
MMIS	Medicaid Management Information System
NCPDP	National Council of Prescription Drugs Program – An ANSI accredited group that maintains a number of standard formats for use by the retail industry.

Acronym/ Word	Description
NDC	National Drug Code – A unique 11-digit number assigned to drugs that identifies the manufacturer, drug, strength, and package size of each drug.
NEIC	National Electronic Insurance Clearinghouse
NPI	National Provider Identifier - Numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.
OMHSAS	Office of Mental Health and Substance Abuse Services
PCP	Primary Care Physician
PHI	Protected Health Information
POA	Present on Admission
POS	Place of Service – An alpha or numeric code denoting the actual place services are provided.
PROMISe™	Provider Reimbursement and Operations Management Information System (in electronic format)
Provider	An entity enrolled in the Pennsylvania Medical Assistance Program that provides services or supplies to recipients.
QSB	Qualified Small Business
RA	Remittance Advice – A notice sent to providers advising the status of claims received, including paid, denied, in process, and adjusted claims. It includes year-to-date payment summaries and other financial information.
RARC	Remittance Advice Remark Codes
Recipient	Person (client or patient) who is eligible to receive services under Pennsylvania's Medical Assistance Program
Service Type Code	Health Benefit Plan Coverage
SSN	Social Security Number
Taxonomy Code	Lists the code designating the provider type, classification, and specialty.